

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/07/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/16/2010
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NAME OF PROVIDER OR SUPPLIER  MADISON CO PH DEPT CHHA NY 00081940	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 605 NORTH COURT STREET WAMPSVILLE, NY 13163
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G 000

INITIAL COMMENTS

The following statement of deficiencies represents the results of a full recertification survey of the agency's Certified Home Health Agency (CHHA), and Long Term Home Health Care Program (LTHHCP), and an on site complaint investigation of complaint # NY 00081940.

A standard level survey was commenced on 02/25/10. On 03/05/10 deficiencies were identified with nursing services, and the survey was extended to a partial extended survey.

A total of 19 clinical records were reviewed, which included 7 observational home visits. Of the 19 clinical records, 5 were LTHHCP records (patients # 3, 4, 8, 17, 18) with 2 observational home visits (patients # 3, 4).

Clinical records # 3, 10, 12 19 were reviewed as part of the complaint investigation. The complaint was substantiated.

The following required waived services were reviewed; medical social work (Patients # 5), and nutritionist services (Patient # 11). There were no patients identified who were receiving the required waived services of respiratory therapy during the survey.

The optional waived services of home delivered meals and personal emergency response system (PERS) were reviewed (Patients # 3, 4; 8, 18). On 03/01/10 and 03/02/10 observational home visits were conducted for patients # 3 and 4 respectively. The agency does not provide any additional optional waived services.

G 000

RECEIVED

MAY 07 2010

NYS Dept. of Health  
Central NY Regional Office

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

*[Signature]*

Director of PH

4/30/10

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 000	Continued From page 1  The following contracts were reviewed for required and optional waived services on 03/15/10: medical social services, nutritionist services, home delivered meals, PERS.  Additionally reviewed during the survey were the agency's: policy and procedure manual; Professional Advisory Committee, and Governing Body meeting minutes for the most recent twelve months; OBQI Adverse Event Outcome Report for the period of August 2009 to October 2009; Quality Assurance program; complaint investigation log; on-call log; contracts for professional services; emergency preparedness plan; and 16 personnel records. Interviews were conducted with the Director of Patient Services, Deputy Director of Health, Supervising Nurses, and Therapy Supervisor.  * It should be noted that 2 of the deficiencies cited in this report (G 143, G 171), are repeat deficiencies from the 07/20/07 recertification survey (event ID GNT 411), and 5 of the deficiencies (G 140, G 144, G 159, G 172, G 250) are repeat deficiencies from both the 07/20/07 recertification survey and the 07/08/08 follow up survey (event ID GNT 412).	G 000		
G 118	484.12(a) COMPLIANCE WITH FED, STATE, LOCAL LAWS  The HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations. If State or applicable local law provides for the licensure of HHAs, an agency not subject to licensure is approved by the licensing authority as meeting the standards established for licensure.	G 118	G 118 484.12(a) Compliance with Federal, State and Local Laws 1. The scope of practice of the LPN per section 6902 of Article 139 of the NYS Education law as well as the State Education Department Scope of Practice of the LPN letter of 2005 to be reviewed by the ADPS/ DPS and CFC for regulations in assigning LPN duties. 2. Present to staff that LPNS would be assigned to patients for the observation, recording, and reporting of subjective and objective data to the RN.	3/17/10          4/29/10

*accepted 5/21/10*



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G 118	Continued From page 2  This STANDARD is not met as evidenced by: Based on a review of 19 patient records, and interviews with the Director of Patient Services (DPS) and Supervising Nurses, there was evidence in 4 records that LPNs are being assigned responsibilities which are outside their scope of practice. Specifically, assessment is not within the scope of practice for an LPN per Section 6902 of Article 139 of the NY State Education Law. This is clarified in a letter issued by the State Education Department on September 2005, entitled "The Scope of Practice of Licensed Practical Nurses", which states that assessment is not within the privilege of an LPN, and that the roles of RN and LPN are not interchangeable. Patients # 3, 10, 12, 19  Examples are as follows:  1. Patient # 3 was admitted to the agency's Certified Home Health Agency (CHHA) on 12/30/09 with a primary diagnosis of fractured rib and secondary diagnosis of chronic obstructive asthma. The 12/30/09 plan of care documented Skilled Nursing (SN) visits were to be made 1 - 2 times per week for 8 weeks for assessment. The RN failed to visit the patient from 12/30/09 to 01/11/10, however, the LPN performed a comprehensive systems assessment of the patient on 01/08/10. The RN failed to assess the patient from 01/12/10 to 01/25/10, and the LPN assessed the patient on 01/21/10. The RN failed to visit the patient 01/29/10 to 02/12/10, and the LPN assessed the patient on 02/04/10, and 02/07/10.  The surveyor reviewed the patient record on 03/05/10. No additional information was provided.	G 118	3. Present to staff that LPNS would only be assigned to established patients where the RN frequencies have been met. 4. Present to staff that LPNS would only be assigned to patients with stable wounds to provide physician ordered wound care. 5. Present to staff that LPNS may respond to telemonitor alerts as directed by the RN for the purpose of data collection to be reported to the RN for interpretation and intervention. 6. Present to staff that LPNS can be assigned to patients requiring medication prepours with fully reconciled medication orders. 7. The MCDOH policy on utilization of LPNS in home care will be revised to reflect the specifics of # 2-6. 8. LPN assignments will be reviewed daily by the ADPS' prior to the start of the workday to ensure that the assignments are within the scope of practice. 9. LPN scope of practice will be addressed at the April 29, 2010 staff meeting to include items 2-8 by the DPS with copies of the the revised MCDOH policy being distributed. 10. The LPN chart audit tool will be utilized to ensure the scope of practice is appropriate.  <i>Accepted 5/21/10 H. O. Martin</i>	4/29/10  4/29/10  4/29/10  4/29/10  4/29/10  3/16/10  4/29/10  4/28/10	

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G 118

Continued From page 3

G 118

2. Patient # 12 was admitted to the CHHA on 01/21/10. The 01/21/10 plan of care documented Skilled Nursing visits were to be made 2 times per week for 1 week, then 1 time per week for 8 weeks for patient assessment. The RN failed to assess the patient from 1/22/10 - 02/04/10, and the LPN assessed the patient on 02/02/10; The RN failed to assess the patient from 02/04/10 - 02/25/10, and the LPN assessed the patient on 02/11/10. The RN failed to assess the patient after 02/25/10, however, the LPN performed a comprehensive system assessment of the patient on 03/04/10.

The patient record was reviewed by the surveyor on 03/10/10 with the DPS and Supervising Nurses. No additional information was provided.

3. Patient #10 was admitted to the agency on 09/30/09. The 09/30/09 plan of care documented SN visits were to be made 2 times per week for 2 weeks, then 1 time per week for 7 weeks for assessment. The RN failed to assess the patient from 09/30/09 to 10/13/09, and the LPN performed a comprehensive system assessment of the patient on 10/05/09.

The patient record was reviewed by the surveyor on 03/10/10 with the DPS and Supervising Nurses. No additional information was provided.

4. Patient #19 was admitted to the agency on 09/12/09. The 01/10/10 plan of care documented SN visits were to be made 2 - 3 times per month for 1 month, then 2 times per month for 1 month for assessment. The RN failed to assess the patient from 01/13/10 to 03/10/10, and the LPN

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G 118	Continued From page 4 performed a comprehensive system assessment of the patient on 01/27/10.	G 118		
G 128	The patient record was reviewed by the surveyor on 03/15/10 with the DPS and Supervising Nurses. No additional information was provided. 484.14(b) GOVERNING BODY  A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.  This STANDARD is not met as evidenced by: Based on a review of 19 clinical records, Professional Advisory Committee (PAC) meeting minutes and Governing Body meeting minutes for the past 12 months, evidence is lacking in 19 clinical records that the Governing Body effectively oversees the operation and management of the agency. Patients # 1 - 19  Failure of the Governing Body to provide adequate oversight and direction of the agency has the potential for unmet patient needs, and possible agency wide negative patient outcomes.  Specifically, evidence is lacking that the following Governing Body responsibilities are being performed:  - Ensuring that the agency is in compliance with all state and local laws, and that all professional personnel are functioning within their scope of practice. G 118, J 308, J 1156, J 1276, J1308, J 1412, J 1416, J 1420, J 1424, J 1444, J 1456, J 1460, J 1476  - Ensuring that supervision of all patient care is	G 128	G 128 484.14(b) Governing Body  1. QA/Professional advisory board/ committee will meet monthly and perform concurrent/comprehensive chart audits on a minimum of 15 charts per quarter. 2. Quarterly the Deputy Health Director will provide QA committee/PAB with a written report/analysis of trends and agency wide patient care issues. 3. QA committee/PAB will make recommendations to resolve patient care issues and an action plan will be developed using the Beacon Health Performance Improvement Plan format. 4. Written QA report of trends, issues and recommendations as well as the action plan will be presented quarterly to the Public Health Committee/Board of Health during the regularly scheduled monthly meetings as part of the CHHA report given by the DHD/DPS and Medical Consultant. 5. A minimum of a quarterly review of the POC will take place at the PHC/BOH meetings with an update on specific actions which have been completed and any barriers encountered. The Quality Investigation Summary Report by Beacon Health will be utilized for this purpose. 6. Minutes of these PHC/BOH joint meetings will show documentation of QA reports, review of POC and recommendations.	4/28/101 4/28/10 4/28/10 5/2010 7/2010 5/2010

*Accepted 5/11/10  
H. DeMunster*

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G 128	Continued From page 5 provided and readily available. Specifically, that supervisors are ensuring that: case coordination and case management are being performed; patients receive the necessary services based on a professional assessment of the patient's needs; plans of care are completed and followed; nursing assessments are complete and accurate. G140, 143, G 144, G 158, G 159, G 171, G 172  - Ensuring that the agency's record keeping system provides a mechanism to ensure the patient record includes: an accurate plan of care which addresses each patient's needs; current assessments which readily identify the patient's response to treatment and change in status; a current representation of the patient's condition. See G 140, G 236.  - Ensuring internal agency audits are of sufficient scope to identify quality of care issues and deficient practices, and that resolutions are developed and implemented. G250  - Exercising its overall management and supervision of the agency. There is insufficient evidence that the Governing Body understood it's responsibility to provide oversight and direction to the agency. Specifically, although there is evidence the trended Quality Assurance (QA) results were presented to the Governing Body Body's Public Health Services Committee monthly from 04/27/09 - 12/21/09, the Governing Body failed to identify that the action plans developed by the Professional Advisor Committee/QA committee had consistently failed to resolve the continuing problems identified. See G 243, G 250  - Ensuring that the agency is consistently functioning in full compliance with all applicable	G 128	G 128 8. The transition of the assignment of a homecare staff nurse with extensive QA experience will continue as this role is developed. This development of this role and future QA guidelines will be driven by use of the Beacon Health tool "Headstart to QI improvement in Homecare". 9. The roles of the PAB committee will be fully developed utilizing the tool "Guidelines for the PAC by Beacon Health. These guidelines will be reviewed at the 4/28/10 PAB/PAC committee meeting. <i>Responsible Party: DPS</i>  10. Recruitment by the DPS and the Deputy Health Director (DHD) will continue to enhance the membership of the PAB/PAC. <del>Dr. Margaret Argentine</del> , Director of the BSN Program at Morrisville College has joined the PAC to attend her first meeting on 4/28/10.  <i>as agreed upon w/ the DPS by phone on 5/14/10</i> <i>St Demarzio</i>  <i>accepted 5/21/10</i> <i>St Demarzio</i>	12/2010  12/2010	

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G 128	Continued From page 6	G 128			
G 140	<p>rules and regulations as outlined in this report.</p> <p>484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE</p> <p>Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).</p> <p>This person, or similarly qualified alternate, participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 19 clinical records, and interviews with the Director of Patient Services (DPS) and Supervising Nurses, there is no evidence in 19 records that supervisory responsibilities are being performed. Although there is evidence the DPS and Supervising Nurses were reviewing patient records with the Skilled Nurses (SNs) at the start of care, and periodically thereafter, the Supervising Nurses are failing to identify problems as outlined in this survey.</p> <p>Additionally, evidence is lacking: the supervisors are reviewing the patient records every 2 weeks with the SNs. Specifically, on 03/15/10 the surveyor interviewed the DPS. The DPS stated that it is expected that the Supervising Nurses review patient records with the SNs every 2 weeks, and record the reviews on a form entitled "MCDOH Home Care Case Conference". Patients # 1 - 19.</p>	G 140	<p>G 140 484.14 (d) Supervising Physician or Registered Nurse</p> <p>1. A case conference policy will be developed and case conference tool revised by the DPS to include the frequency of every two weeks and components of the case conference to include: review of accurate and complete plan of care, implementation of plan of care, ensure that MD is consulted at the SOC/ROC or change in condition, review of nursing assessment to verify patient status and continuing needs, review appropriate use of ancillary services utilizing the MCDOH triggering events resource, verification of adequate and timely communication between the ancillary services, physician, nursing staff and supervisors, appropriate utilization of LPNS on the case and adequate and timely supervision of the HHA (every 2 weeks by an RN). This will be presented at the 4/29/2010 staff meeting.</p> <p>2. The QA concurrent audit tool will be revised by the nurse assigned to QA reflect that a case conference is done every two weeks with ADPS/DPS and staff nurses.</p> <p>3. The weekly ADPS/DPS conferences will include a review of status of nurse case conferences. Barriers to case conference completion will be identified and reported to the DPS for reporting to the PAB/PAC.</p> <p>4. The PT Coordinator/DPS will develop a policy addressing coordination of patient information between all of the disciplines to allow for more timely exchange of</p>	<p>5/1/2010</p> <p>4/28/2010</p> <p>4/28/2010</p> <p>5/30/2010</p>	

*accepted 5/1/10  
J. Rema*

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G 140	Continued From page 7  Failure of the DPS and Supervising Nurses to provide adequate oversight and direction of patient care has the potential for agency wide unmet patient needs, and possible negative patient outcomes.  Specifically, the following supervisory functions were not being performed:  - ensuring that all personnel assigned to provide patient care perform tasks commensurate with their scope of practice. See G118  - Ensuring that coordination/case management is being performed consistently and that all pertinent patient information is communicated to all individuals providing care, and documented in the clinical record. See G 143  - Ensuring that plans of care are developed in consultation with the physician, and that the plans of care are being implemented. See G 143, G 158  - Ensuring that each patient's plan of care is complete and accurate for all diagnoses, medications and treatments, and is being implemented. See G 158, G159 ^  - Ensuring that the agency's professional staff promptly alerts the physician to any changes in the patient's condition that may suggest a need to alter the plan of care. See G 164  - Ensuring that nursing assessments and reassessments are complete and accurately reflect the patient's status and continuing needs. See G171, G172	G 140	5. Training on this policy will be presented by the DPS to staff in the June 2010 staff meeting.  6. A documentation submission policy will be established and presented to staff by the DPS which will ensure that documentation is complete, accurate and accessible to all staff team members caring for the patient. The policy includes the CMS guidelines for submission of data, revisit notes to be locked no later than 7 days from patient visit, all wound and IV documentation must be completed at the end of the work day on the patient visit date, weekend and holiday SOC must be completed for review by the supervisor by the next county business day, corrections after documentation review are to be made within 48 hours of documentation return to PCN, nurses activity records are to be entered in their entirety at the end of each day worked, documentation is to be current prior to a scheduled leave.  <i>Accepted 5/21/10 J. Demantone</i>		6/23/2010  3/30/2010

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G 140	Continued From page 8	G 140	484.14 (g) Coordination of Patient Services	
	- Ensuring that Supervising Nurses are aware of the current status of each patient; clinical records contain pertinent and current findings, and that plans of care are being updated to meet patient's changing needs. G144, G 159, G 236		1. The DPS will develop a policy for case management for all primary care nurses in homecare. This policy is to include: Purpose: to facilitate care coordination among disciplines/ensure a multidisciplinary care plan/allow for ongoing assessment of the patient's disease process/provide and coordinate prompt changes in the patient's plan of care/coordinate communication with the physician/vendors and the payer/collaboratively attends to the patient and family education needs/identifies areas for process improvement/compiles documentation for the payer and addresses ongoing approvals for services and care delivery needs/captures and monitors data for outcome improvement.	5/3/2010
G 143	484.14(g) COORDINATION OF PATIENT SERVICES  All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.  This STANDARD is not met as evidenced by: Based on a review of 19 clinical records, and interviews with the Director of Patient Services (DPS), and Supervising Nurses, there is no evidence in 11 records:  - significant information is being exchanged consistently between individuals responsible for developing and implementing the plan of care - the Skilled Nurses (SNs) have a clear understanding of the role of the home care nurse in providing case management / coordination. Patients # 1, 3, 5, 6, 8, 9, 10, 12, 13, 16, 18,  Lack of adequate case management and case coordination has the potential for unmet patient needs and possible negative patient outcomes.  Patient #10 was identified on 08/2009 - 10/2009 OBQI Report for discharge to the community with ongoing medication needs.	G 143	2. Training will be developed and implemented by the DPS using the homecare primary nurse case management model to include the importance of the structured case management model, organization and management of tasks for the RN, and strategies for increasing the efficiency of case management duties and responsibilities.  3. The case conference form will be revised to assure that case management responsibilities are identified, actions are specified, follow up and documentation are complete.  4. The QA audit tool will be revised to demonstrate that case management duties	6/23/2010  5/30/2010  5/30/2010  4/21/2010

*Accepted 5/31/10  
H. Roman*

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 143	<p>Continued From page 9</p> <p>Examples are as follows:</p> <p>HV</p> <p>1. Patient #5 was admitted to the Certified Home Health Agency (CHHA) on 10/23/09 directly from a Skilled Nursing Facility (SNF). The SNF discharge nutritional assessment documented: the patient was 6 feet 1 inches, weighed 108 lbs, had an ideal weight of 184 lbs. The agency's 10/23/09 plan of care documented a diagnosis of malnutrition, and the patient was to receive total parenteral nutrition (TPN) via a peripherally inserted central catheter (PICC) line. On 03/03/10 the surveyor conducted an observational home visit with the SN, and observed that the patient was quadriplegic and emaciated. The SN failed to coordinate the following:</p> <p>- A nutritional plan to meet the patient's needs. Specifically, on 10/23/09 the SN performed the initial nursing assessment, and documented "regular diet... nutrition/hydration / no problems identified". The SN failed to identify that the patient had unmet nutritional needs.</p> <p>On 11/13/09 the SN visited the patient and documented the patient had a poor appetite, and on 11/25/09 documented the PICC line and TPN had been discontinued due to infection. Despite the patient's severely compromised nutritional status, and now total dependence on oral intake to meet his nutritional needs, the SN failed to assess the patient's caloric intake and failed to identify the need for an evaluation by a nutritionist until one month later on 12/21/09.</p> <p>On 12/21/09 and 02/17/10 the SN documented the patient had declined a nutritionist evaluation,</p>	G 143	<p>are adequate and documentation is complete.</p> <p>5 (cont'd) The flow chart for active patients will be used to identify the specific deficiencies for each patient/the corrective action taken/date completed and that corrections can be tracked. The ADPS will be responsible for assuring that each nurse has completed corrections/addendums. This will include patient # 3,4,5,6,11,13,14,16,7,18,and 19. Pts 1,2,7,8,9,10,12,and 15 have been discharged.</p> <p><i>See attached as agreed upon w/ the OPS By phone on 5/14/10</i></p> <p><i>Accepted 5/11/10 H. Romanow</i></p>		



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G 143	<p>Continued From page 10</p> <p>however, the SN failed to discuss this with the physician, and during the home visit conducted by the surveyor, the patient stated that he would like to have an evaluation by the nutritionist.</p> <p>- An effective plan to meet the patient's psychosocial needs. Specifically, on 12/18/09 the SN visited the patient and documented the patient was refusing to eat due to the marital problems with his wife. The SN failed to discuss this with the physician or identify the need for a social work evaluation until one month later on 01/14/10.</p> <p>On 01/14/10 the social worker visited the patient for an evaluation, however, the social worker failed to address the patient's refusal to eat. The social worker documented the patient; was having problems with his wife, suffered from depression, declined services from "mental health", had denied the need for continued social work visits. Although the social worker reported these findings to the physician, she failed to assess if she felt further visits were needed, and failed to coordinate a plan with the physician and SN, to address the patient's depression.</p> <p>On 03/03/10 the surveyor interviewed the SN case manager. Although the social worker documented that she left a detailed message for the SN to update her on the patient, the case manager stated they had never discussed the patient's status. The SN stated to the surveyor she "wished she could have seen the social work evaluation". Additionally, the SN stated that continued visits from the social worker may have been beneficial to the patient, as the patient had not been seen by "mental health" for a very long time.</p>	G 143			

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- An effective plan to ensure the patient's safety. Specifically, on 01/22/10 and 01/27/10 the SN documented the patient had told her he did not want his wife touching him. During the 03/03/10 interview of the SN by the surveyor, the SN told the surveyor she had observed the wife handling the patient roughly, and that the patient had been known to call Adult Protective Services (APS) about his wife in the past. The SN failed to document this, and failed to report her findings to the Supervising Nurse, physician, social worker, and APS.

- A plan for the care of the suprapubic catheter. Specifically, during the 03/03/10 observational home visit, the surveyor observed that the patient had a suprapubic catheter to gravity drainage. The privately hired caregiver stated that she assumed full responsibility for the care, and monthly changing of the catheter, however, the 10/23/09 initial nursing assessment documented that the wife was responsible for the care and changing the catheter. Although the SN visited the patient at least one time per week from 10/23/09 - 02/20/10, the SN failed to: ever assess the catheter site, document a plan for the catheter care on the 10/23/09, 12/22/09, or 2/20/10 plans of care, observe if the wife had been independent and correctly caring for the catheter, observe if the private caregiver was independent and correctly caring for the catheter, discuss with the physician if he was in agreement with the private caregiver changing and caring for the catheter.

- An adequate plan for pressure ulcers. Specifically, although the patient had 3 decubitus ulcers on his back / coccyx, and one on his left heel, the SN failed to coordinate a plan with the

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G 143	<p>Continued From page 12</p> <p>patient, caregiver, and physician for repositioning on a regular schedule, or a plan for care of the heel ulcer. Specifically, the caregiver stated to the surveyor that she had been changing the dressing on the patient's heel "for a long time", however, neither the 02/20/10 plan of care, or updated physician orders included wound care for this wound, and the SN never observed the caregiver performing the wound care.</p> <p>During the 03/03/10 interview of the SN by the surveyor, the surveyor questioned the SN as to why the plan did not include wound care for the patient's heel decubitus. The SN stated "because they didn't tell me". The SN failed to understand that it was her responsibility to assess the patient's skin integrity and coordinate a wound care, and pressure relief plan.</p> <p>On 03/04/10 the surveyor reviewed the patient record with the DPS and Supervising Nurses. No additional information was provided.</p> <p>2. Patient #10 was admitted to the CHHA on 09/03/09. The 09/03/09 initial nursing assessment documented the patient had dementia, was confused, lived alone, the son and daughter were taking turns staying with the patient.</p> <p>On 10/05/09 the LPN visited the patient and documented the patient was being left alone and was not safe, and reported this to the SN case manager. On 10/13/09 the SN visited the patient and discharged the patient from the agency without coordinating a plan to ensure the patient's safety. Specifically, the SN documented: the daughter and son took turns providing care and supervision and lived within walking distance of the patient. The SN discussed with the son "the</p>	G 143			

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patient's safety at times when she is left alone"; the son responded that the patient is checked frequently and the patient does not wander about the house. The SN documented she closed the case at the request of the family. The SN failed to: determine if the family's plan to leave the patient alone was safe for the patient; discuss her findings with the physician, Nursing Supervisor and if necessary APS prior to closing the case.

The patient record was reviewed with the DPS and Supervising Nurses on 03/10/10. No additional information was provided.

3. Patient # 8 was admitted to the agency's Long Term Home Health Care Program (LTHHCP) on 01/12/10. The SN failed to coordinate a plan to meet the patient's needs as follow:

The 01/12/10 initial nursing assessment documented the patient: was "mentally challenged", and that 2 times per month the patient had chemotherapy. The patient had to return to the physician the day following the chemotherapy for a neulasta injection, and again the day after that, for the port to be de-accessed. Although the SN visited the patient every 2 weeks immediately following the chemotherapy, the SN failed to coordinate a plan to provide these post chemo therapy procedures at home for the patient.

On 03/10/10 the surveyor interviewed the SN. The SN told the surveyor that it was very difficult for the patient to visit the physician 3 days in a row 2 times per month for her chemotherapy regimen. The surveyor questioned the SN as to why she wasn't performing these procedures for the patient at home, and the SN stated that the

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G 143	<p>Continued From page 14</p> <p>agency could not be reimbursed for the neulasta. There is no documentation in the record of this problem, or of any attempt by the SN to resolve the problem. Additionally, although the SN was visiting the patient 2 times per month immediately following the chemotherapy, the SN stated she had not been de-accessing the port because she just followed what the patient had been doing prior to the home care services, and the SN never discussed with the physician that she could de-access the port at home.</p> <p>- The 01/12/10 plan of care documented SN visits were needed 2 times per month, and failed to specify that the visits were needed every 2 weeks immediately following the chemotherapy for assessment, per the surveyor's interview with the SN on 03/10/10.</p> <p>- The 01/12/10 plan of care documented that a weight loss of 5 lbs. was to be reported to the physician. On 01/12/10 the SN visited the patient and documented the patient weighed 129 lbs. On 01/29/10 the SN visited the patient and documented the patient weighed 122 lbs., which represented a 7 lb weight loss. The SN documented that weight loss was to be expected. The SN failed to report the weight loss to the physician per the plan of care, and failed to consult with the physician regarding reportable weight parameters, prior to changing the plan of care.</p> <p>The patient record was reviewed with the DPS and Supervising Nurses on 03/10/10. No additional information was provided.</p> <p>4. Patient # 9 was admitted to the CHHA on 10/03/09. The SN failed to coordinate a complete</p>	G 143			

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G 143	<p>Continued From page 15</p> <p>and accurate plan of care for antibiotic IV administration. This resulted in the antibiotics not being infused at the rate specified in the plan of care for 4 days as follows:</p> <p>- The 10/03/09 plan of care documented cipro and vancomycin (antibiotics), each to be infused over 1 hour via a PICC line every 12 hours. The plan, however, documented conflicting orders for the vancomycin. Specifically the plan documented vancomycin in dextrose 1 gm in 200 cc normal saline using dial-a flow tubing and via PICC line, however, the plan also documented infuse 1 gm in 250cc normal saline every 12 hours over 1 hour at a rate of 250cc per hour. Additionally, the plan failed to include the times the son was to infuse each antibiotic, and the sequence in which they were to be administered.</p> <p>- On 10/03/09 at 9:00 AM - 11:00 AM the SN case manager conducted the initial nursing assessment and documented: the SN case manager called the IV durable medical equipment (DME) vendor to report it was taking greater than 1 hour for the IV antibiotics to infuse, she had requested a pump, the DME vendor had refused to provide a pump. Although the SN case manager documented she had called the physician and the Supervising Nurse to discuss the plan of care, the SN case manager failed to: discuss the infusion problem with the Supervising Nurse, report to the physician that the antibiotics were not being infused over 1 hour as specified in the plan of care, coordinate a plan to address the problem.</p> <p>- At 9:30 PM on the same day the patient called the on call Supervising Nurse to report he "could not get the IV to run, or flush the gray lumen".</p>	G 143			

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The Supervising Nurse instructed the patient by phone to use the alternate lumen. The SN case manager failed to specify on the plan of care which lumen the antibiotics were supposed to be infused through, and the Supervising Nurse failed to notify the physician of the infusion problem during the evening, and of her instructions to the patient to use the other lumen.

As a result, despite the fact that this was the patient's first time infusing these medications at home independently, and there were problems identified earlier in the day with the IV infusion, the Supervising Nurse failed to visit the patient that evening, and the SN case manager did not visit the patient until the following day on 10/04/09.

- On 10/05/09 the SN case manager visited the patient and documented she reported to the DME vendor that it was taking at least 2 hours to infuse each antibiotic. The SN case manager documented the DME vendor had responded that they had been having problems with the type of IV tubing that the patient was using, and that they would send another infusion system to the patient. The SN case manager failed to ascertain when the vendor expected to have the new system to the patient, or discuss the unresolved problem with the Supervising Nurse, and physician. As a result, the IV antibiotics failed to infuse over 1 hour for another 48 hours, Specifically:

- On 10/06/09 the SN documented another call to the DME vendor and again inquired about getting an IV pump. The vendor responded that they would deliver the new infusion system on the following day, 10/07/09.

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FORM CMS-2567(02-99) Previous Versions Obsolete      Event ID: WPUQ11      Facility ID: 1877      If continuation sheet Page 18 of 44

accepted static  
H. Demuthius



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G 144	Continued From page 18 place, and that information essential to caring for the patient is being exchanged among all employees assigned to care for the patient. See G 143  - The Supervising Nurses are reviewing the patient records every 2 weeks with the Skilled Nurses (SNs). Specifically, on 03/15/10 the surveyor interviewed the DPS. The DPS stated that it is expected that the Supervising Nurses review patient records with the SNs every 2 weeks, and that the record reviews are documented on a form entitled "MCDOH Home Care Case Conference", or in the patient record. There is no evidence in the patient records, or the supervisory notes that this frequency was being adhered to by the Supervising Nurses. Patients # 1 - 19  - The Supervising Nurses are identifying problems with care coordination when they do conduct the case conferences. See G 236  The above information was reviewed by the surveyor with the DPS on 03/15/10. The DPS stated that interdisciplinary case conferences take place only as needed, and are not scheduled at regular intervals.	G 144	as discussed w/ the DPS by phone on 3/14/10; all RN's are now required to submit follow up nursing assessments within 7 days of visit. Comprehensive assessments required to be submitted per CMS guidelines A Demanding		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.  This STANDARD is not met as evidenced by: Based on a review of 19 clinical records and interviews with the Director of Patient Services	G 158	G 158 484.18 Acceptance of Patients, Plan of Care and Medical Supervision  1. The DPS will develop a documentation submission policy that will provide time frame requirements for the submission of clinical documentation. Failure to meet these requirements will result in progressive employee discipline. This policy has been completed and will be presented to the PAB/PAC on 4/28/2010.	4/28/2010	

*Accepted 5/10/10  
A Demanding*

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(DPS) and Supervising Nurses there is no evidence in 17 records the established plan of care is consistently being followed. Patients # 1 - 14, 16, 18, 19

Failure of agency staff to follow the plan of care has the potential for patients receiving care inconsistent with the physician's orders, unmet patient needs, and possible negative patient outcomes.

Examples are as follows:

1. In 2 of 2 records reviewed where the patients were participants in the agency's telehealth program, the Skilled Nurse (SN) failed to report values to the physician that were consistently outside of the reporting parameters established in the plan of care: Patients # 3, 6

Specifically:

Patient # 6 was admitted to the Certified Home Health Agency (CHHA) on 01/12/10, and was admitted to the telehealth program on 02/19/10. The 02/12/10 plan of care documented that blood pressure values not within 160-120/ 90-40 should be reported to the physician. The 02/11/10 - 02/19/10 Telehealth Trend Report documented that between the dates of 02/19/10 and 03/05/10 the the patient had exceeded the high blood pressure parameters 14 times in 14 days. The SN failed to notify the physician of this persistent trend.

Patient # 3 was admitted to the agency's Long Term Home Health Care Program (LTHHCP) on 12/30/09, and was admitted to the telehealth program on 01/07/10. The 02/28/10 plan of care

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2. The DPS will develop a telehealth monitoring policy which will include appropriate use of monitor in homecare, prescreening requirements, adding the monitor to the POC, monitor use including actions to be taken for patients alerting outside of parameters and writing orders for telehealth monitoring and communications with the ordering physician by faxing trend sheets weekly and prn. This policy has been completed and will be presented to the PAB on 4/21/2010.

3. The case conference sheet will be revised to assure that the PCN/CFC has met the requirements of the telehealth policy.

4. The QA audit tool will be revised to include a focused audit on telehealth patients to include surveillance of trend reporting and compliance with ordered parameters.

*Accepted 5/21/10  
J. Donnanthe*

4/29/2010

4/28/10

4/28/10

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documented that spot oxygen saturation (SpO2) values below 88% should be reported to the physician. The 02/13/10 - 02/25/10 Telehealth Trend Report documented that the patient's SpO2 value was below 88% 8 times in 12 days. The SN failed to notify the physician of this persistent trend.

The RN failed to identify that both of the above patients were experiencing persistent trends that were reportable to the physician per the plan of care. Instead the RN was facilitating the patients return to acceptable parameters, almost daily, by calling the patients, and / or re-testing, and / or dispatching SNs to the patient's home to obtain vital signs.

Patient records #6 and #3 were reviewed with the DPS and Supervising Nurses on 03/05/10 and 03/06/10 respectively. The DPS provided an undated policy titled "Telehealth Monitoring Procedure". The procedure was merely a screening tool to identify patients who would be potential candidates for the telehealth program, and failed to include the process for reporting values that are out of parameters to the physician.

2. Patient # 18 was admitted to the LTHHCP on 12/29/09. The 12/29/09 plan of care documented SN visits 2 times per week for 9 weeks for wound care and assessment of the patient's left lower leg wound. The SN failed to visit the patient per the plan of care, and failed to notify the physician as follows: The SN failed to visit from 12/29/10 - 01/05/10, 01/07/10 - 01/14/10, 01/14/10 - 01/21/10, 02/04/10 - 02/11/10, 02/18/10 - 02/25/10.

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NAME OF PROVIDER OR SUPPLIER  MADISON CO PH DEPT CHHA	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 605 NORTH COURT STREET WAMPSVILLE, NY 13163
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G 158	<p>Continued From page 21</p> <p>Additionally, although the SN visited the patient from 12/29/09 to 01/21/10, the SN failed to measure wound #1 during this time period.</p> <p>The patient record was reviewed on 03/15/10 with the DPS and Supervising Nurses. No additional information was provided.</p> <p>3. Patient # 13 was admitted to the CHHA on 02/18/10. The SN failed to follow the 02/18/10 plan of care, and failed to notify the physician as follows:</p> <ul style="list-style-type: none"> <li>- The plan of care documented the SN was to visit the patient 2 times per week for 2 weeks, then 1 time per week for 3 weeks for patient assessment. On 03/11/10 the surveyor requested the patient record which documented the following: The SN failed to assess the patient between 02/18/10 and 03/02/10. Specifically on 02/22/10 and 02/23/10 the patient refused SN visits, on 02/24/10 the SN documented she visited the patient and assessed the patient's vital signs, however, there was no assessment documented, and on 02/26/10 the SN visited the patient and conducted a home health aide supervision, however, the SN did not assess the patient.</li> <li>- The plan of care documented the patient was to be weighed every week when able to stand, however, the patient was never weighed after the initial assessment, and the SN failed to document why the patient had not been weighed.</li> </ul> <p>The patient record was reviewed on 03/12/10 with the DPS and Supervising Nurses. No additional information was provided.</p>	G 158		
G 159	484.18(a) PLAN OF CARE	G 159		

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G 159	Continued From page 22  The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted; nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.  This STANDARD is not met as evidenced by: Based on a review of 19 clinical records, and interviews with the Director of Patient Services (DPS) and Supervising Nurses there is no evidence in 12 records the plan of care developed is of sufficient scope to meet the patient's needs. Patients # 2, 3, 4, 5, 7, 8, 9, 11, 12, 14, 16, 18  Patient #9 was identified on the 8/2009 - 10/2009 OBQI Adverse Event Report for deteriorating wounds.  Lack of a complete and accurate plan has the potential for unmet patient needs and possible agency wide negative patient outcomes.  Examples are as follows:  HV 1. Patient #5 was admitted to the Certified Home Health Agency (CHHA) on 10/23/09. The 02/20/10 plan of care was incomplete or inaccurate as follows:  - On 03/03/10 the surveyor conducted an	G 159	1. Progresa will be advised by the Director of Administrative Services that POC documentation 485/487 overlaps and prints out in a manner that is not able to be followed by clinicians. A request for technical support to alleviate this problem will be submitted. Guidance was provided by Progresa support in alleviating this problem.  2. A training module will be presented to staff at the April 28, 2010 to staff to ensure that staff are competent in the technical specifications for this documentation.  2. The ADPS/PCN will review the 485/487 with the review of the SOC/ROC/Recert and at case conferences.  3. The QA audit tool will be utilized to ensure that the POC is complete and accurate.  4. Specific survey POC related deficiencies will be presented to all nursing staff at the next staff meeting on 4/28/2010.  5. All specific survey POC related deficiencies will be reviewed 1:1 with the PCN by the ADPS/DPS.  6. The documentation committee, which includes field staff nurses and nursing supervisors will develop tools to serve as a guideline for PCN's to develop and document the POC. These guidelines will be presented in monthly team training meetings. This will be initiated at the 5/2010 meeting.	3/30/2010	4/29/2010	4/21/2010	4/28/2010	4/30/2010	4/23/2010	5/30/2010

*Accepted 5/10/10  
H. D. Martin*

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G 159	<p>Continued From page 23</p> <p>observational home visit with the Skilled Nurse (SN). The surveyor observed that the patient was quadriplegic, however, this diagnosis was not documented on the plan of care.</p> <p>- The plan documented the patient's wife was to care for the patient's suprapubic catheter, however, the plan was not specific for what the care included.</p> <p>- During the observational home visit, the surveyor observed that the patient had 3 wounds on his back, and one on his left heel, however, the plan included wound care for only 2 of the back wounds, and not the heel wound.</p> <p>- The following medication discrepancies on the plan of care were identified during the observational home visit by the surveyor:</p> <p>The plan included Total Parental Nutrition (TPN) infusion via a peripherally inserted central catheter (PICC), and IV famotidine, however, the surveyor observed that the patient did not have an IV PICC line, and on 11/25/09 the SN had documented that the PICC line and TPN had been discontinued due to infection.</p> <p>The patient stated he was taking hydrocodone for pain as needed, however, this was not on the plan of care</p> <p>The plan included paxil 20 mg per day, however, the patient stated that was discontinued 2-3 weeks ago. There was no physician order to discontinue this</p> <p>The plan included xanax 0.25mg 3 times per day, however, the patient stated this was discontinued</p>	G 159	<p>8. HHQI Medication Management Best Practices will be presented to staff at the June 2010 staff meeting.</p> <p>9. All IV charts will be audited in the next quarter and the IV audit tool will be revised to demonstrate surveillance of IV record deficiencies.</p> <p>10. The QA nurse will advise the ADPS by use of the audit tools the deficiencies identified. Those deficiencies will be incorporated into the case conferences as a means to implement corrective action.</p> <p>11. Ongoing revision and update of IV policy will continue with guidance and approval of the MCDOH medical consultant. Policies will be presented to the PAB/PAC at the 7/21/2010 meeting.</p> <p><i>Accepted 5/11/10 H. Roman</i></p>	<p>6/23/2010</p> <p>7/21/2010</p> <p>7/21/2010</p>

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Continued From page 24  
in October 2009

The patient stated he was taking valium as needed at bedtime, however the plan did not include this, and there was no physician order for this.

The plan included baclofen 20mg one time per day, however, the patient stated he is taking this 2 times per day.

The plan included bactrim 800 mg 2 times per day, however, the patient stated this had been discontinued 2 weeks prior, when cymbalta had been started, which was on the plan of care.

The patient stated he was taking cipro 250 mg 2 times per day, however, this was not on the plan of care.

The plan included amitiza 8 mcg daily, however, the patient stated he is taking this as needed, approximately 4 times per week.

The plan of care included colace 100mg 2 times per day, however, the patient stated he is taking this as needed approximately 4 time per week.

On 03/03/10 the surveyor interviewed the SN. The SN stated that she reviews the patients specific individual medications with patients only during initial assessments, and that on recertification assessments she asks the patients if they have had any new medications prescribed.

The patient record was reviewed on 03/04/10 with the DPS and Supervising Nurses. No additional information was provided.

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G 159	<p>Continued From page 25</p> <p>2. Patient #9 was admitted to the CHHA on 10/03/09. The 10/03/09 plan of care failed to include an accurate, and understandable, wound care plan. Specifically, the plan of care documented: "Change wound vac dressing and perform wound care to left foot on Mon, Wed, Fri. RN to measure wound weekly. If vac fails, may apply wet to dry NS until wound vac arrives, use aquacel DSD daily and wrap with kerlix, secure with tape...left foot wound, using clean technique, every day dressing change, son performing dressing change per MD orders: cleanse left foot wound with 4x4 and NS, pat dry, apply aquacel AG, cut to fit size of wound bed, cover with 4x4 gauze, place ABD then wrap with gauze cling...change dressing right foot, clean technique, 3 days a week - M-W-F, cleanse wound with NS. Fit black foam to wound. KCI wound vac to right foot wound, if vac fails, apply normal saline wet to dry dressing. wound vac continuous suction 125 mmHg to right foot wound...change wound vac dressing and perform wound care to left foot and right foot on Mon, Wed, Fri. RN to measure wound weekly. If vac fails may apply wet to dry NS dressing."</p> <p>The plan of care was unclear for what dressing was to be applied to which foot, and how often, and was not written in a manner that treatment orders could be followed.</p> <p>On 03/09/10 the patient record was reviewed by the surveyor with the DPS and Supervising Nurses. They agreed that the above plan of care did not contain instructions for wound care that could be followed by the SNs.</p> <p>HV</p> <p>3. Patient #2 was admitted to the CHHA on</p>	G 159		



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Continued From page 26  
11/02/09. On 01/21/10 the patient returned home from the hospital following a PICC line placement. The 01/21/10 updated plan of care failed to include the following:

- a plan to assess for PICC line migration, including reporting parameters to the physician for external catheter length. As a result, although the SN visited the patient 12 more times after the initial assessment, the SN failed to ever re assess the PICC for migration, including measuring the external catheter length.
- a plan for care for the nephrostomy. Specifically, although the SN documented in the 01/21/10 ROC nursing assessment that the patient had a new nephrostomy "tube" draining to gravity, there was no plan for the care of the catheter.
- a complete and accurate wound care plan. Specifically, on 03/01/10 the surveyor conducted an observational home visit with the SN, and observed the SN applying a dry sterile dressing to an old drain site on the patient's abdomen. The plan of care, however, documented the dressing should be tegaderm.
- a complete an accurate medication plan . Specifically, the following discrepancies in the plan of care were identified by the surveyor during the observational home visit:

The plan documented bifidophilus 1 tab daily, however the patient stated she was taking it 3 time per day.

The plan documented K Phos 1 tablet 2 times per day, however, the patient stated she had not taken this for 1 month as directed by the

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G 159	Continued From page 27 physician.  The plan documented lasix 80 mg 2 times per day, however the patient stated she had been taking 200mg in the AM and 100 mg in the PM since 02/09/10 as directed by the physician  The plan of care documented metamucil 1 time per day and magnesium oxide 2 times per day, however, the patient stated she had not taken these for 2 weeks as directed by her physician.  The patient stated she was taking cipro 250 mg every day, however, this was not included in the plan of care.  The plan documented lantus 100 insulin 36 units subcutaneous injection at bedtime, however the patient stated she was taking 34 units as directed by the physician.  The patient stated that her insulin sliding scale had been changed on 02/02/10 and 02/04/10, however, there were no physician orders reflecting the 02/04/10 sliding scale changes.  Additionally, the plan of care documented zosyn (antibiotic) IV every 6 hours using a gemstar pump. The patient record was reviewed by the surveyor with the DPS and Supervising Nurses on 03/08/10. The Supervising Nurse clarified that one new IV bag with tubing was to be hung every 24 hours, and the pump then administered the medication automatically every 6 hours throughout the day. The plan of care failed to clarify this.	G 159			
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE	G 164			

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G 164	<p>Continued From page 28</p> <p>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 19 clinical records, and interviews with the Director of Patient Services (DPS), and Supervising Nurses, there is no evidence in 6 records that the physician is consulted when changes in the patient condition occur. Patients # 2, 6, 9, 14, 17, 18</p> <p>Failure to consult with the physician when changes are identified in the patient's condition resulted in a negative outcome for patient #9, and has the potential for agency wide unmet patient needs and negative patient outcomes.</p> <p>Patient #9 was identified on the 08/2009 - 10/2009 OBQI Adverse Event Report for deteriorating wounds.</p> <p>Examples are as follows:</p> <p>1. Patient # 9 was admitted to the Certified Home Health Agency (CHHA) on 10/03/09.</p> <p>- Between the dates of 10/04/09 and 10/26/09 the Skilled Nurse (SN) visited the patient 7 times and documented at 5 visits the patient's wound had a strong or foul odor. Although the SN documented on 10/19/09 that she had instructed the patient to report any odor coming from the wound site, the SN failed to report the wound odor that she had observed to the physician.</p> <p>- On 10/19/10 the SN visited the patient and documented redness at the PICC line site, which</p>	G 164	<p>G 164 Periodic Review of Plan of Care</p> <p>1. The designated QA nurse will review conduct a full audit on any adverse outcome charts. A minimum of 5 wound charts will be audited per quarter.</p> <p>2. The audit tool for adverse outcomes will be revised by the designated QA nurse to reflect surveillance that the nurse conducted adequate follow up including notification of the physician on any change in patient condition.</p> <p>3. The wound care case conference form has been developed and will be instituted as part of the case conference by the ADPS for all patients receiving wound treatment and will be scanned into the permanent record.</p> <p>4. The established documentation committee will develop guidelines for the accurate and complete documentation of pain in the patient record. The policy and procedure for pain documentation will be revised and presented to the PAB/PAC at the 4/28/2010 meeting.</p> <p>5. The DPS will develop training on pain assessment in the homecare setting to include protocol for notifying the MD of changes in pain status and present it to staff in a monthly team training meeting.</p>	<p>7/21/2010</p> <p>5/19/2010</p> <p>4/26/2010</p> <p>4/28/2010</p> <p>6/1/2010</p>	

*include protocol for  
notifying the MD for all  
changes in pt. condition  
H. Demerly*

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G 164	<p>Continued From page 29</p> <p>she did not document at the prior visit on 10/12/09. The SN failed to report this change to the physician.</p> <p>On 10/27/09 the SN documented the patient had been admitted to the hospital for an elevated temperature and infected peripherally inserted central catheter (PICC).</p> <p>The patient record was reviewed on 03/09/10 with the DPS and Supervising Nurses, no additional information was provided.</p> <p>2. Patient # 6 was admitted to the CHHA on 02/12/10. The SN failed to report changes in the patient's condition to the physician as follows:</p> <ul style="list-style-type: none"> <li>- On 02/12/10 the SN documented that the patient weighed 238 lbs, and on 02/18/10 the SN documented the patient weighed 221 lbs. The SN failed to report the 17 lb weight loss in a 6 day period to the physician</li> <li>- On 02/18/10 the SN visited the patient and documented: she was making the visit as a result of an elevated blood pressure and heart rate identified on telehealth readings, the patient was agitated, the patient was experiencing left shoulder pain, the patient was refusing to use her oxygen, the patient refused to go to the emergency room as directed by the SN. The SN left the patient's home with the patient in this potentially life-threatening situation, and failed to immediately report these symptoms to the physician.</li> </ul> <p>The patient record was reviewed with the DPS and Supervising Nurses on 03/05/10. No additional information was provided.</p>	G 164			

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Continued From page 30

3. Patient # 18 was admitted to the agency's Long Term Home Health Care Program on 12/29/09. The 12/29/09 plan of care included duragesic patch 50 mcg, change patch every 72 hrs, lidoderm 5% apply patch around perimeter of lower left leg wound each dressing change, oxycodone/acetaminophen 5 - 500 mg every 2 hours as needed for pain. The SN failed to report the following changes in patient condition to the physician:

- On 02/09/10 the SN visited the patient and documented the patient's blood pressure to be 112/78. On 02/16/10 the SN visited the patient and documented the patient: was fatigued, had a blood pressure of 70/40, stated that her blood pressure was frequently low due to dialysis. The SN left the patient alone in this potentially life threatening situation, and failed to report the low blood pressure to the physician.

Additionally, the SN failed to report changes in the patient's pain status to the physician, and failed to advocate for adequate pain control for the patient. This resulted in the patient experiencing uncontrolled pain for over 3 weeks as follows:

- On 12/29/09 the SN documented in the initial nursing assessment the patient had been taking increased amounts of hydromorphone for pain during the past 2-3 days and was concerned about not getting adequate pain relief. The SN documented the physician was aware, however, there is no indication how the SN knew this, and the SN failed to report the increasing pain to the physician.

- On 01/05/10 the SN visited the patient and

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NAME OF PROVIDER OR SUPPLIER  MADISON CO PH DEPT CHHA	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 605 NORTH COURT STREET WAMPSVILLE, NY 13163
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G 164	<p>Continued From page 31</p> <p>documented the patient: was experiencing moderate to severe pain of the left lower and upper leg, had the pain for a long time, was taking hydromorphone with little relief; reported she had a nerve block scheduled for the following week. The SN failed to report the patient's increasing pain to the physician, or advocate for adequate pain control for the patient.</p> <p>- On 01/07/10 the SN visited the patient and documented the patients pain was now elevated to 4 of 5, however, the SN failed to report this to the physician.</p> <p>- On 01/14/10 the SN documented the patient was continuing to experience a pain level of 3 of 5, despite taking hydromorphone at least 3 times in the past 24 hours. The plan of care documented the patient could take the hydromorphone every 2 hours as needed. The SN failed to identify the patient was not maximizing the pain medication per the plan of care, report this and the patient's unresolving pain to the physician, clarify what the maximum daily dose for the hydromorphone was.</p> <p>This resulted in the patients pain medication not being increased to a stronger narcotic (oxycodone) by the physician until 01/23/10, when the patient discussed her pain management with the physician, as documented by the SN in the 01/23/10 clinical note.</p> <p>The patient record was reviewed by the surveyor on 03/15/10 with the DPS and Supervising Nurses. No additional information was provided.</p>	G 164		
G 171	484.30(a) DUTIES OF THE REGISTERED NURSE	G 171		

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G 171

Continued From page 32  
The registered nurse makes the initial evaluation visit.

This STANDARD is not met as evidenced by:  
Based on a review of 19 clinical records, and interviews with Director of Patient Services (DPS), and Supervising Nurses, there is no evidence in 9 records the initial nursing assessments are of sufficient scope to ensure that all patient needs are met. Patients # 2, 3, 5, 6, 7, 14, 15, 16, 18

Lack of complete and accurate nursing assessments has the potential for unmet patient needs and possible negative patient outcomes.

Examples are as follows:

1. Patient # 3 was admitted to the Certified Home Health Agency (CHHA) on 12/22/09. The 12/22/09 plan of care documented hydrocodone - acetaminophen 5 - 500 1-2 tablets every 6 hours as needed for pain, and ibuprofen 200 mg 1-2 tablets every 6 hours as needed for pain. The 12/22/09 initial nursing assessment documented: the patient was experiencing a pain level of 1 - 5 out of 10, the pain was not easily relieved, the patient stated she did not take her pain medication for fear of constipation. The SN failed to:

- assess which medication the patient was referring to, assess if the patient understood that ibuprofen does not have constipating side effects and could be safely taken, or if the patient required the use of a bowel medication which may have allowed the patient to take either of the pain medications as needed.

G 171

G 171 484.30 (a) Duties of the Registered Nurse

1. See G 164 # 5

2. An in-service will presented by Martha Phillips RN ADPS, former dialysis nurse on the assessment and care of the renal patient to include expected dietary measures.

3. The documentation committee will establish guidelines for the complete documentation of diabetic teaching which will be presented in monthly team trainings.

4. The DPS/ADPS will devote a team training meeting to reviewing the Diabetic Patient Teaching manual/Diabetic Zone tool with staff.

5. The established policy and procedure to be followed when a patient is not found for a scheduled nursing visit will be reviewed by the DPS/ADPS at the April 29th staff meeting.

6. The DPS/PT Coordinator will develop a policy on the follow up assessment, intervention and documentation of reported falls. This policy will be presented to the PAB/PAC for approval and presented to staff at the April 2010 staff meeting.

7. The DPS/ADPS will review all SOC/ROC done by nurses not having completed the 3 month orientation period. All IV, wound and pediatric SOC/ROC's will be reviewed prior to 485 being sent-out to ensure accuracy and completeness of plan of care.

6/1/2010

7/28/2010

6/30/2010

4/29/2010

4/29/2010

*Accepted 5/21/10  
H. Demartino*

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G 171	<p>Continued From page.33</p> <p>The patient record was reviewed by the surveyor on 03/05/10 with the DPS and Supervising Nurses. No additional information was provided.</p> <p>2. Patient # 18 was admitted to the agency's Long Term Home Health Care Program (LTHHCP) on 12/29/09. The 12/29/09 initial nursing assessment was incomplete or inaccurate as follows:</p> <ul style="list-style-type: none"> <li>- The assessment documented the patient had a pain level of 3 on a scale of 5, however, failed to describe the location of the pain.</li> <li>- The 12/29/09 plan of care documented hydromorphone 2 mg every 2 hours as needed for pain, duragesic patch 50 mcg to be changed every 72 hours, lidoderm patch to be applied prior to dressing changes. The assessment documented the patient was not getting adequate pain relief from the medications, however, the SN failed to specify the frequency of pain medication the patient was taking, and assess if the patient was fully utilizing the pain medication per the plan of care.</li> <li>- The 12/29/09 plan of care included a duragesic patch 50 mcg to be changed every 72 hours, however, the SN failed to assess the integrity of the patch, or observe if the patient / caregiver was applying and changing the patch correctly.</li> <li>- The 12/29/09 initial nursing assessment documented the patient was attending dialysis 3 times per week, and that the patient was following a "prescribed diet." The SN failed to specify the type of diet the patient was to follow, and documented in the 12/29/09 plan of care the</li> </ul>	G 171			



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G 171	Continued From page 34 patient was on a regular diet. The HHA plan documented the patient was on a renal diet.  The patient record was reviewed by the surveyor on 03/15/10 with the DPS and Supervising Nurses. The Supervising Nurse stated it was unlikely the patient was on a regular diet.  3. Patient # 6 was admitted to the CHHA on 02/12/10. The 02/12/10 initial nursing assessment was incomplete or inaccurate as follows:  - The 02/12/10 plan of care documented arixtra injections every 24 hours, however, the 02/12/10 initial nursing assessment documented the patient had no injectable medications, and the SN failed to observe if the patient was independent and correctly administering the injections.  - The 02/12/10 initial assessment documented the patient was independent in performing fingerstick blood sugar testing, however, the SN failed to observe if the patient was performing the procedure correctly, and failed to assess the frequency with which the patient was testing her blood sugar.  The patient record was reviewed by the surveyor on 03/05/10 with the DPS and Supervising Nurse. No additional information was provided.	G 171			
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse regularly re-evaluates the patients nursing needs.  This STANDARD is not met as evidenced by:	G 172	G 172 484.30 (a) Duties of the registered nurse  1. The DPS will develop and present a policy which will specify guidelines outlining the necessity for re-evaluation of patients with changes in condition.  2. Training on this policy will be presented at team training meetings by 5/30/2010 by the DPS.  3. Surveillance for identification of patient changes in condition, need for re-evaluation visits and follow up actions to include notification of the physician will be added to the case conference sheet by the DPS.  4. The QA audit tool will be revised to reflect surveillance of patient changes in condition, need to re-evaluation, follow up actions to include MD notification and degree of timeliness will be completed by the QA nurse.	5/30/2010  5/30/2010  5/30/2010	

*Accepted 5/21/10  
H. D. Mordine*

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G 172	<p>Continued From page 35</p> <p>Based on a review of 19 clinical records, and interviews with the Director of Patient Services (DPS), and Supervising Nurses, there is no evidence in 7 records the skilled nursing (SN) reassessments are of sufficient scope to identify changes in the patient's condition which may require re-evaluation and/or modification in the plan of care. Patients # 6, 9, 12, 14, 16, 17, 18</p> <p>Failure to perform complete and accurate nursing assessments has the potential for unmet patient needs, and possible negative patient outcomes.</p> <p>Examples are as follows:</p> <p>1. Patient # 12 was admitted to the Certified Home Health Agency (CHHA) on 01/21/10. The 01/21/10 initial nursing assessment documented the patient had a seizure disorder, and that the patient's wife thought the patient may have had a seizure the prior evening. The nursing assessments were incomplete as follows:</p> <p>- On 02/04/10 the SN visited the patient, however, failed to assess if the patient had experienced any more seizures.</p> <p>- On 02/11/10 the home health aide visited the patient, and documented she had reported to the SN that the patient: had been up 3 - 4 times the prior evening, had fallen, had sustained a "scrape" on her arm, would probably be having some bruising. The SN failed to visit and assess the patient until 2 weeks later on 02/25/10.</p> <p>The patient record was reviewed by the surveyor on 03/10/10 with the DPS and Supervising Nurses. No additional information was provided.</p>	G 172	<p>G 172 cont'd</p> <p>5. See G171 #4 Policy on patient assessment and documentation of falls</p> <p>6. See G171 #3,4 Use of Diabetic Teaching Manual and Documentation guidelines for diabetic teaching</p> <p>7. See G 171 #5 Review of policy on actions taken for patients not home/ not found for a scheduled nursing visit.</p> <p><i>Accepted 5/11/10 JD Remar</i></p>	<p>4/30/2010</p> <p>5/19/2010</p> <p>4/29/2010</p>	

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G 172	<p>Continued From page 36</p> <p>2. Patient #16 was admitted to the CHHA on 01/24/10 with a primary diagnosis of aftercare for total hip replacement. The 01/24/10 initial nursing assessment documented that the hip replacement was due to a fractured hip following a fall.</p> <p>On 02/05/10 the SN visited the patient and documented the patient: had fallen the prior evening (02/04/10), had sustained a chipped tooth and left eye laceration, was going to the emergency room for x-rays. The SN failed to follow up with the patient, or reassess the patient until 3 days later on 02/08/10.</p> <p>The patient record was reviewed by the surveyor on 03/09/10 with the DPS and Supervising Nurse. No additional information was provided.</p> <p>HV</p> <p>3. Patient # 6 was admitted to the CHHA on 02/12/10. The 02/12/10 plan of care documented a secondary diagnosis of diabetes, home glucose testing, and Januvia (oral hypoglycemic). The nursing assessments were incomplete as follows:</p> <ul style="list-style-type: none"> <li>- Although the SN visited the patient on 02/12/10, 02/18/10, 02/26/10, the SN failed to: ever observe if the patient was performing the finger stick blood sugar testing correctly; discuss with the physician, and teach the patient, what the blood sugar reporting parameters to the physician were; discuss what to do if the patient's blood sugar was elevated.</li> <li>- Although there are additional nursing visits dated 02/17/10, 02/19/10, and 02/22/10 there were no nursing assessments performed on those days.</li> </ul>	G 172			

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G 172	<p>Continued From page 37</p> <p>- On 02/26/10 the SN documented she instructed the patient to test her blood sugar at least 1 time per day, however, the SN failed to: assess how frequently the patient had been testing her blood sugar, specify when during the day the patient should be checking, clarify with the physician how often the patient should be checking her blood sugar.</p> <p>On 03/03/10 the surveyor made an observational home visit with the LPN. During the visit, the LPN handed a diabetic teaching book to the patient. There is no evidence a SN provided any diabetic teaching materials to the patient prior to this visit, which was over a 3 week period after the initial nursing assessment. Following the conclusion of the LPN visit, the patient told the surveyor: the physician wanted her to test her blood sugar 3 times a day, however, she had only been testing 1 time per day, and she had always wondered what to do if her blood sugar was high.</p> <p>The patient record was reviewed by the surveyor on 03/05/10 with the DPS and Supervising Nurses. No additional information was provided.</p> <p>4. Patient # 13 was admitted to the CHHA on 02/18/10. On 03/05/10 the LPN documented she had attempted to visit the patient, and reported to the RN the patient was not home, and could not be found. There were no follow up contacts documented to assess if the patient was safe.</p> <p>The patient record was reviewed by the surveyor on 03/12/10 with the DPS and Supervising Nurses. The DPS stated that she had conducted a teaching session specifying what actions staff were to take when a patient was not home and</p>	G 172			

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G 172	Continued From page 38	G 172			
	not found, however, the agency did not maintain a written policy that had been reviewed by the professional advisory committee.				
G 236	484.48 CLINICAL RECORDS	G 236	G 236 484.48 Clinical Records		
	A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.		1. See G 158 #1 Documentation Submission Policy	4/28/2010	
			2. The ADPS will monitor the unprocessed notes report on a weekly basis and communicate with staff during case conferences as to documentation status.	4/19/2010	
			3. The progressive disciplinary process will be instituted for failure to meet the requirements of the documentation submission policy.	4/28/2010	
			4. The DPS/DHD will report outstanding documentation status and necessary progressive disciplinary actions taken to the PAB/PAC quarterly and to the Board of Health and Public Health Committee on a monthly basis as we are currently doing. The board/committee meeting notes will reflect recommendations and response to action plans by members.	5/24/2010	
	This STANDARD is not met as evidenced by: Based on a review of 19 clinical records, and interviews with the Director of Patient Services (DPS) and Supervising Nurses, there was no evidence in 6 records that all pertinent information contained in the clinical record was current and complete. The agency failed to maintain a policy specifying a time frame within which the agency staff is required to submit documentation into the patient record following a patient contact.		Accepted 5/21/10 H. Monahan		
	On 03/01/10 the surveyor interviewed the DPS who stated that late submission of documentation by the SNs had been an ongoing problem for the agency, and that it is the agency's practice to take SNs "out of the field" if they have greater than 10 outstanding progress notes to be submitted. A 06/03/09 memorandum sent to home care staff nurses titled "Regarding vacation requests and documentation" documented: "prior to leaving for vacation all staff is expected to have no more				

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G 236 Continued From page 39

than 10 outstanding notes." The memo was a one time directive and failed to specify ongoing expectations of the SNs regarding a required time frame for submission of clinical notes.

The agency's interpretation of acceptable standards does not facilitate timely submission of documentation by employees, and resulted in lengthy delays, in some instances exceeding 1 month, in the submission of progress notes by the Skilled Nurses. Patients # 2, 3, 6, 7, 13, 19

Failure to maintain current clinical records results in information concerning patient status and patient response to treatment not being readily available to all clinicians responsible for implementing the plan of care, or to supervisors responsible for overseeing the delivery of patient care, and is questionable for accuracy. This has the potential for unmet patient needs, and possible agency wide negative patient outcomes.

Examples are as follows:

1. Patient # 7 was admitted to the Certified Home Health Agency (CHHA) on 02/04/10. The 02/04/10 plan of care documented Skilled Nurse (SN) visits were to be made 1 - 2 times per week for 8 weeks. There was no evidence in the patient record the SN visited after 02/09/10.

On 02/25/10 the DPS documented a case conference, and that the patient was making good progress. There is no evidence the DPS based her determination on current information. Specifically, the DPS failed to: document who participated in the case conference, identify and discuss with the SN that there had been no SN visits documented since 02/09/10.

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G 236	<p>Continued From page 40</p> <p>On 03/05/10 the surveyor reviewed the patient record with the DPS and Supervising Nurses. The DPS stated that SN notes for 02/12/10, 02/17/10, and 02/25/10 had been submitted by the SN following the surveyors request for the record on 03/01/10.</p> <p>2. Patient # 6 was admitted to the CHHA on 12/12/09. The 02/12/10 plan of care documented SN visits 2 times per week for 1 week, then 2-4 times per month for 2 months. On 02/18/10 the RN documented she visited the patient, the patient was having difficulty breathing, was experiencing left shoulder pain, had refused to go to the emergency room. There was no evidence in the record the RN had ever re-assessed the patient.</p> <p>On 02/24/10 there was a case conference note by the DPS documenting the patient was found to be hypertensive, tachycardiac, and was started on verapamil. There is no evidence the DPS based her findings on current information, clarified with the SN whether she had followed up with the patient, and physician following the patient's significant change in condition.</p> <p>On 03/05/10 the surveyor reviewed the patient record with the DPS and Supervising Nurses. The DPS stated the SN submitted progress notes for visits made on 02/19/10 and 02/22/10 following the surveyors request for the record on 03/03/10.</p> <p>3. Patient # 19 was admitted to the CHHA on 09/12/09. Between the dates of 01/10/10 - 02/10/10 the SN visited the patient every 2 weeks to refill insulin syringes. There was no evidence</p>	G 236			

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G 236	<p>Continued From page 41</p> <p>in the patient's record that the insulin syringes had been filled after 02/10/10. Specifically, there was no SN visit documented from 02/10/10 - 03/10/10, and the 03/10/10 note documented only that a SN visit had been made, but included no assessments. Although the Supervising Nurse documented a case conference with the SN on 03/04/10 and documented "Q 2 wk insulin", the Supervising Nurse failed to identify and discuss with the SN that there was no documentation in the patient record indicating that the SN had filled the patient's syringes since 02/10/10.</p> <p>On 03/15/10 the patient record was reviewed by the surveyor with the DPS and Supervising Nurses. The DPS stated that the computer showed a SN visit had been made on 02/24/10, and that the SN had not yet submitted the nursing note.</p> <p>4. Patient # 2 was admitted to the CHHA on 11/20/09. The SN documented that she had visited the patient on 02/02/10, 02/03/10, 02/04/10, 02/06/10, 02/07/10, 02/09/10, 02/10/10. With the exception of vital signs documented on 02/10/10, the SN failed to document any assessment information for those dates as of 03/08/10.</p> <p>On 03/04/10 the Supervising Nurse documented a case conference with the Skilled Nurse. There is no evidence the Supervising Nurse reviewed information that was current for the patient, and failed to identify and discuss with the SN the missing nursing notes.</p> <p>On 03/08/10 the surveyor reviewed the patient record with the DPS and Supervising Nurses. No additional information was provided.</p>	G 236			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/07/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/16/2010
NAME OF PROVIDER OR SUPPLIER  MADISON CO PH DEPT CHHA			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 605 NORTH COURT STREET WAMPSVILLE, NY 13163		
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G 250	<p>484.52(b) CLINICAL RECORD REVIEW</p> <p>At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.</p> <p>This STANDARD is not met as evidenced by: Based on a review of: the agency's policies and procedures, quality assurance program, Professional Advisory Committee (PAC) and Governing Body meeting minutes for the past 12 months, and interviews with the Director of Patient Services (DPS), and the Deputy Director of Health, evidence is lacking the agency has a functional quality assurance / quality improvement program which has identified and corrected recurring systemic problems associated with the development and implementation of plans of care. Although the quality assurance program identified trended areas which required improvement, the agency failed to develop action plans that were effective in resolving the problems. Specifically:</p> <p>- For the 1st and 2nd quarters of 2009 the quality assurance committee identified 57 and 75 trends respectively which required improvement. Although the agency developed and implemented an extensive action plan, the agency failed to identify the plan was not effective in resolving ongoing problems such as: incomplete and inaccurate plans of care, failure to follow the plan of care, incomplete and inaccurate nursing assessments, ineffective case coordination/ case management, as identified in this report. See G 143, G 158, G 159, G 143, G 171, G 172</p>	G 250	<p>G 250 484.52 (b) Clinical Record Review</p> <p>1. The 3/16/2010 survey deficiencies will be reviewed by the PAB/PAC</p> <p>2. The DPS will present the Beacon Health "Guidelines for the PAC" which will further clarify and develop the roles of the PAB/PAC member at the April 28, 2010 PAB/PAC meeting. Implementation of these guidelines will continue during meetings until the end of 2010.</p> <p>3. The QA action plan forms will be initiated and updates on progress will be presented to the PAB/PAC at the monthly meetings by the DPS/DHD.</p> <p>4. Focused as well as comprehensive audits will be completed each quarter to include initial assessment SOC on wound, IV, telehealth, HHA, therapy and all adverse outcome records.</p> <p>5. Audit tools will be revised by the designated QA nurse as per recommendations by the quality assurance committee /PAB/PAC.</p> <p>6. Monthly trainings will be developed and presented as identified by audit trending patterns and recommendations of the PAB/PAC starting after the 4/28/2010 meeting. Trends will be categorized and prioritized to manage and organize data to allow the following: monitor individual employee performance/compare and monitor organization performance against benchmarks/monitor performance indicators/set performance goals/identify opportunities for improvement.</p> <p>7. The ADPS will be responsible for meeting with the PCN to provide mentoring for the resolution of issues of deficiency as trended by the QA nurse.</p>	4/28/2010	4/28/2010
				4/28/2010	4/28/2010
				7/21/2010	7/21/2010
				7/21/2010	7/21/2010
				12/2010	12/2010
				4/26/2010	4/26/2010

*Accepted 5/10/10  
St. Dominick*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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G 250	Continued From page 43  - For the 3rd quarter of 2009, the agency identified 67 trends which required improvement, however, failed to develop and implement an effective action plan to address the problems they identified, or that were identified in this report as outlined above.  - For the 4th quarter of 2009, the agency performed only 2 comprehensive patient record reviews. And although there were 13 start of care audits, 3 wound care audits, and 2 IV audits performed, and 42 clinical trends identified, the extensive action plan developed and implemented by the agency was not effective in resolving ongoing problems such as: incomplete and inaccurate plans of care, failure to follow the plan of care, incomplete and inaccurate nursing assessments, ineffective case coordination/ case management, as identified in this report. See G 143, G 158, G 159, G 143, G 171, G 172  - Although 04/15/09 quality assurance meeting minutes documented that records will be reviewed for patients identified on the OASIS adverse event outcome reports, to examine what could be done to prevent future adverse events, the agency failed to provide any evidence of any adverse event audits, including the adverse event of Patient # 9 as identified in this report; or include in the adverse event audit tool a determination of whether the adverse event could have been avoided.	G 250	8. Active recruitment will continue to fill the third ADPS position vacated in November 2009.  9. The transition of a staff nurse into the full time QA assignment will be completed.  10. The QA policy and procedure manual will be revised to reflect changes in policies, procedures and audit forms as recommended by the PAB/PAC.  11. The QA committee will review, trend data and report 15 concurrent charts/1 SOC chart per RN/5 wound charts/3 HHA charts/4 PT charts and all IV and adverse outcome charts per quarter.  12. Trend reports/action plans/response to action plans/barriers to implementing the action plan for quality improvement will be presented to the PAC/PAB. Minutes of the committee meetings will reflect PAC findings including appropriateness, adequacy, effectiveness and efficiency of the QI measures.	ongoing  12/2010  7/21/2010  7/21/2010  7/21/2010	

*Accepted 5/21/10  
H. Demaree*

New York State Department of Health

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J 308	<p>763.3(a)(2) Patient Care</p> <p>763.3 Patient Care.</p> <p>(a) The governing authority shall ensure that a comprehensive array of services is available and provided as needed.</p> <p>.....</p> <p>(2) For a long term home health care program or AIDS home care program, such services shall include as a minimum: nursing services; home health aide services; medical supplies, equipment and appliances; physical therapy; occupational therapy; respiratory therapy; speech-language pathology; audiology; medical social work; nutritional services; personal care; homemaker and housekeeper services.</p> <p>This Regulation is not met as evidenced by: Based on a review of contracts maintained by the agency, and interviews with the Director of Patient Services(DPS), there is no evidence that there is a mechanism in place for patients to receive respiratory therapy or audiology services as required by the Long Term Home Health Care Program (LTHHCP).</p> <p>Specifically, the surveyor interviewed the DPS on 03/11/10, and the DPS stated the agency does not have contracts for respiratory or audiology services, and has not been providing these services to patients.</p>	J 308	<p>J 308 763.3(a) Patient Care</p> <p>1. Recruit for contract respiratory therapist and audiology services through newspaper ads, on Madison County Website by 4/30/2010 and have contracts in place within 30 days.</p> <p><i>Responsible Party: DPS</i></p> <p>2. A policy will be developed by the DPS for field staff to provide guidelines for the identification of LTHHCP patient need for respiratory and audiology services.</p> <p><i>as agreed upon with the DPS by phone on 5/14/10</i></p> <p><i>J DeMonte</i></p> <p><i>accepted 5/21/10</i></p> <p><i>J DeMonte</i></p>	5/30/2010	5/30/2010

Office of Health Systems Management / Office of Long Term Care

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

Version NYS 11/17/2009

5889

WPUQ11

If continuation sheet 1 of 19

New York State Department of Health

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J 308	Continued From page 1  Failure to maintain contracts for all services required by the LTHHCP has the potential for unmet patient needs, and possible agency wide negative patient outcomes.	J 308			
J1156	763.11(a)(10) Governing authority  763.11 Governing authority.  (a)The governing authority shall: ..... (10) ensure the development of a written emergency plan which is current and includes procedures to be followed to assure health care needs of patients continue to be met in emergencies which interfere with delivery of services and orientation of all employees to their responsibilities in carrying out such a plan;  This Regulation is not met as evidenced by: Based on a review of the agency's Emergency Preparedness Policy and Procedure, and interviews with the Director of Patient Services(DPS), there is no evidence the agency's emergency preparedness plan meets all of the requirements outlined in the May 10, 2005 DOH letter to Home Care Services and Hospice Administrators . Specifically, the agency failed to:  - maintain a call down list of agency staff.  - maintain a complete emergency patient roster.  - maintain policies and procedures to assure that the emergency patient roster, and employee call down list are kept updated, including who is responsible for updating them.	J1156	J 1156 763.11 (a) (10) Governing Authority  1. By April 30, 2010 a meeting will be held by the DPS/DHD to perform business process task flow and matrix for maintaining emergency patient roster with all staff involved in process to identify how this is currently being performed and changes that need to be made to ensure the roster is current.  2. The DHD will develop a written policy and submit to the PAB for emergency preparedness specific to the CHHA which meets the requirements of the May 10, 2005 DOH letter to include call down procedures for agency staff, procedures for maintaining a complete emergency patient roster and responsible parties for updating these documents.  3. Policy to presented to CHHA nursing and clerical staff at May 2010 staff meeting.  4. The public health educator for MCDOH will continue to test the call down list per policy developed by the Deputy Health Director. This will be done a minimum of twice yearly with the first test completed by June 30th.	4/30/2010       5/7/2010    5/19/2010   6/30/2010	

*a cefted smile  
L. Demaine*

New-York State Department of Health

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J1156	<p>Continued From page 2</p> <p>Failure of the agency to comply with all applicable New York State emergency preparedness requirements creates the potential for unmet patient needs, and possible agency wide negative patient outcomes in the event of an emergency.</p> <p>Examples are as follows:</p> <p>1. The agency's emergency patient roster was incomplete. Specifically, on 02/25/10 the DPS submitted an emergency patient roster to the surveyor. Of 17 active patients reviewed in this survey (Patients # 1 - 8, 11 - 19) the roster was incomplete for 8 patients, and failed to identify that the patient required electricity to sustain life and/or failed to specify a patient classification. Patients # 2, 3, 6, 7, 11, 13, 14, 15</p> <p>Examples::</p> <ul style="list-style-type: none"> <li>- For patients #13, the 02/18/10 plan of care included oxygen 3 liters continuous via nasal cannula, however, the emergency patient roster failed to document this, and failed to include a patient classification.</li> <li>- For patient # 3, the 02/28/10 plan of care included 4 liters of oxygen continuously via nasal cannula, and albuterol nebulizer treatments every 4 hours as needed, however, the emergency patient roster failed to document this.</li> <li>- For patient # 2 the patient was included in the 02/25/10 emergency patient roster, however, there was no patient classification documented.</li> </ul> <p>Failure of the agency to comply with all applicable New York State emergency preparedness requirements creates the potential for unmet patient needs, and possible agency wide negative</p>	J1156			

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J1156 Continued From page 3

patient outcomes in the event of an emergency.

On 03/12/10 the agency's lack of a complete emergency patient roster was reviewed with the DPS. No additional information was provided.

2. On 03/15/10 the surveyor requested the agency's emergency employee call down list. The DPS submitted a list of active agency employees. The list included telephone numbers, however, there was no procedure delineating the notification process for employees in the event of an emergency.

On 03/15/10 the above findings were reviewed with the DPS. No additional information was provided.

J1156

J1276 763.11(f)(4) Governing authority

763.11 Governing authority.

(f) Maintenance of each agency's HPN accounts shall consist of, but not be limited to, the following:

.....

(4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis

This Regulation is not met as evidenced by: Based on a review of the agency's Health Provider Network (HPN) account on 02/12/10 and 03/15/10, the agency failed to maintain a current, and accurate Communications Directory. Specifically:

J1276

J1276 763.11 (f) (4)

1. HPN policy was completed on 4/1/2010 and will to the PAB 4/28/2010 for approval-draft attached.

2. Policy will be reviewed with HPN coordinators following PAB approval.

3. Agency address and 24/7 contact information is corrected in the communications directory.

4/28/2010

4/20/2010

4/1/2010

*per discussion w/ the DPS + Dep Health on 5/21/10 the HPN coordinator will be responsible for updating the HPN when there*

*a cepted 5/21/10  
A demand*

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J1276	Continued From page 4  - The agency's address was incorrect. The HPN account documented the address to be "County Office Building PO BX 605 Noah Court"  - The e-mail address for the agency's 24 by 7 contact was incorrect and contained the e-mail address for a Director of Patient Services (DPS) who was no longer employed by the agency.  - The agency failed to maintain a policy defining how the above information will be kept updated, and who would be responsible.  On 03/15/10 the above findings were reviewed with the DPS. The DPS confirmed the DPS listed for the 24 by 7 e-mail, no longer worked for the agency.	J1276			
J1308	763.12(a)(3) Contracts  763.12 Contracts.  (a) The governing authority may enter into contracts with individuals, organizations, agencies or facilities, when necessary, to provide or obtain those services required by patients. Such contracts shall specify:  ..... (3) that services provided to the patient by contract shall be in accordance with the plan of care developed by the agency in consultation with all providers of care, as appropriate, and that the contracting party agrees to abide by the patient care policies established by the agency;  This Regulation is not met as evidenced by: Based on a review of 4 patient records of patient's who participated in the agency's Long	J1308	J 1308 763.12 (a) (3) Contracts  1. The coordinating dietician for the snack meal program for Madison County was contacted by the DPS. Verification that all meals delivered are NAS and can modified to NCS for diabetics. The dietician advised that these are the only modifications that can be made. Snack meal programs are a component of the POC which is signed by the physician.  2. A contract with Office of the Aging snack meal program is in place dated 1/1/2010.  3. A policy will be developed by the DPS to include in the nursing plan of care that with LTHHCP patient recertifications and the q2week RN visit for HHA supervision that the frequency, type and patient satisfaction of quality of the meals will be assessed and documented. It will be the responsibility of the PCN to verify with the Snack Meal Program any dietary restrictions of the patient. This policy will be presented to the PAB/PAC for approval.	3/22/2010  1/1/2010  7/21/2010	

*accepted 3/11/10  
At the meeting*

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J1308	<p>Continued From page 5</p> <p>Term Home Health Care Program (LTHHCP), and received home delivered meals or personal emergency response systems (PERS), and interviews with the Director of Patient Services (DPS), there is no evidence in 4 records, the agency has developed policies, or included in their vendor contracts, procedures to monitor the implementation and quality of waived services provided by contractual agreement, specifically, home delivered meals and PERS. Patients # 3, 4, 8, 18</p> <p>Failure to ensure the quality of waived services has the potential for unmet patient needs, and possible agency wide negative patient outcomes.</p> <p>Examples are as follows:</p> <p>1. Based on a review of 4 records where the plan of care included PERS services, and interviews with the DPS, there is no evidence in 3 records the agency had a formal process or contractual clause for monitoring the maintenance and proper functioning of the PERS units. Specifically, the agency contract failed to specify: how the staff is educated and supervised, how the PERS units are to be checked, at what frequency the PERS units should be checked; who is responsible for checking the units, including the agency's responsibilities and the vendor's responsibilities, what action should be taken if it is discovered the PERS unit is not functioning properly. Patients # 3, 4, 17, 18</p> <p>Specifically:</p> <p>HV</p> <p>- Patient # 3 - the 02/28/10 plan of care documented the patient had a PERS, however, failed to include a plan to check the PERS button</p>	J1308	<p>4. A policy will be developed by the DPS to include in the nursing POC that with LTHHCP patient recertification visits compliance with the HHA care plan (PERS) has been assessed for function, maintenance, person(s) responsibility for assessment, frequency of assessment and procedure for repairing or replacing non functional equipment. The HHA care plan will reflect the HHA's responsibility for routine PERS checks. The policy will be presented to the PAB/PAC for approval at the 7/21 meeting. This policy and relevant training and revisions of the care plan will be presented during the May 2010 HHA meeting.</p> <p>5. A contract for the PERS through Oneida Health Care Facility and Loretto is in place dated 1/1/2010.</p> <p>6. The home health aide audit tool will be revised by the QA nurse to reflect surveillance of compliance to PERS monitoring and responsibility and will be presented to the PAB/PAC at the July 21st meeting.</p> <p><i>Accepted 5/21/10 A Demarino</i></p>	<p>7/21/2010</p> <p>1/1/2010</p> <p>7/21/2010</p>



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J1308	<p>Continued From page 6</p> <p>to ensure it was functioning properly.</p> <p>On 03/02/10 the surveyor conducted an observational home visit with the Skilled Nurse (SN). The SN checked the patient's PERS button, and found it not to be functioning. The surveyor asked the SN what the policy is for checking the PERS, and she stated that she checked it on the initial and recertification assessments (every 60 days). The CMS - 485 plan of care failed to include this, and the 12/30/09 home health aide (HHA) care plan documented the PERS button should be checked once per month by the HHA. There is no documentation in the patient record indicating the PERS had been checked prior to the observational home visit, or how long the PERS had not been functioning.</p> <p>The patient record was reviewed on 03/05/10 with the DPS and Supervising Nurses. The DPS stated the agency does not maintain a policy specifying how the agency ensures the PERS units are functioning properly, including who is responsible for checking.</p> <p>- Patient # 18 - The patient was admitted into the agency's LTHHCP on 12/29/09. On 12/29/09 the SN and Department of Social Services (DSS) staff member documented in the 12/29/10 - 04/28/10 Home Assessment Abstract that the patient had declined a PERS, however, the Home Health Aide (HHA) documented that the patient was wearing a PERS button on 01/12/10, 01/21/10, 01/26/10, 02/04/10, 02/16/10.</p> <p>The SN failed to identify and address how the HHA was checking a PERS when neither the 12/29/09 CMS 485 plan of care, or the 12/29/10 - 04/28/10 Home Assessment Abstract included a PERS.</p>	J1308			

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J1308	<p>Continued From page 7</p> <p>The patient record was reviewed on 03/15/10 with the DPS and Supervising Nurses. No additional information was provided.</p> <p>- Patient #8 - The 01/12/10 CMS 485 plan of care documented the patient had a PERS and HHA services. The patient record failed to contain a current HHA care plan, and there was no evidence the PERS button was checked by the SN or HHA during the 01/12/10 - 03/12/10 certification period.</p> <p>The patient record was reviewed on 03/10/10 with the DPS and Supervising Nurses. No additional information was provided.</p> <p>2. In 4 of 4 patient records (100%), where the patient was receiving home delivered meals, there is no evidence the agency: monitored the frequency and quality of the home delivered meals, or if the meals were within specified diet restrictions. Patients # 3, 4, 8, 18</p> <p>- Patient # 4 - The 12/10/09 - 04/09/10 Home Assessment Abstract completed by the SN and DSS staff documented the patient was to receive home delivered meals 3 times per week. The 02/12/10 CMS 485 plan of care documented the patient was on a no added salt diet, however, failed to include home delivered meals. Additionally, there is no evidence the SN ever monitored the frequency and quality of the meals.</p> <p>- Patient # 3 - The 12/22/09 - 04/21/10 Home Assessment Abstract completed by the SN and DSS staff documented the patient was to receive home delivered meals 2 times per week. The 12/30/09 CMS 485 plan of care included a new diagnosis of diabetes, and a no concentrated</p>	J1308			

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J1308	<p>Continued From page 8</p> <p>sweets diet. The plan of care failed to include home delivered meals, and there is no evidence: the special diet was communicated to the vendor by the SN, the SN ever monitored the quality and frequency of the meals, the SN monitored if the special diet was being adhered to by the vendor.</p> <p>- Patient #18 - The 12/29/09 - 04/28/10 Home Assessment Abstract completed by the SN and DSS staff documented the patient was to receive home delivered meals 2 times per week. There is no evidence the SN clarified the type of diet the patient was on, and communicate this to the vendor, or assess if home delivered meals were appropriate for the patient. Specifically:</p> <p>The 12/29/09 CMS 485 plan of care documented the patient was undergoing hemodialysis. The plan also documented the patient was on a regular diet, however, the 12/29/09 initial nursing assessment documented the patient was following a "prescribed diet". A 09/15/09 HHA care plan documented the patient was on a "renal diet". The SN failed to clarify the patient's diet restrictions, and communicate this to the vendor.</p> <p>On 01/07/10 there was a hand written note added to the 12/29/09 - 04/28/10 Home Assessment which documented the patient cancelled the home delivered meals "due to her diet restrictions." It was the patient, and not the SN who identified the meal vendor could not meet her diet restrictions.</p> <p>On 03/11/10 the surveyor interviewed the DPS and LTHHCP nurse. The LTHHCP nurse stated it was the SN case manager's responsibility to make the referral to the meal vendor and communicate any special instructions, and that she (the LTHHCP RN) checks every 6 months</p>	J1308			

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J1308	Continued From page 9  with the patient to determine if the patient was satisfied. There was no evidence in any of the above examples that this occurred. The DPS stated that the agency does not have a policy for monitoring the home delivered meals.  The patient record was reviewed with the DPS and Supervising Nurses on 03/15/10. The Supervising Nurse stated it was likely that the patient was on a renal diet.	J1308			
J1412	763.13(c) Personnel  763.13 Personnel.  The agency shall ensure for all personnel: ..... (c) that the health status of all new personnel is assessed prior to assuming patient care duties. The assessment shall be of sufficient scope to ensure that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.  This Regulation is not met as evidenced by: Based on review of 4 personnel records (employees # E, H, I, J, P) where the agency contracted directly with a therapist, nutritionist, or social worker, and interviews with the Director of Patient Services (DPS), there is no evidence in 4 records that the employee had received a health assessment prior to assuming duties of the job, and / or the pre-employment health assessment	J1412	J1412 763.13 (c) Personnel  1. Review and revise employee health policy to reflect that all employees and contract staff must receive an initial health assessment signed by an MD, NP or PA and present policy to the PAB/PAC by 4/28/2010.  2. Clarify and designate responsible staff for ensuring that these requirements are met.  3. Revise the check list of required health and immunizations for employees and contract staff that can be used by the DPS to verify proof of all required immunizations are on file in the employee record prior to the start of employment. This has been completed.  4. Business process matrix will be completed for tracking employee/contract requirements including health, immunization, license, certifications, mandatory trainings, and performance appraisals. This process was initiated on 4/8/2010.  5. Develop and implement collaboratively with the IT department a secure data base for tracking employee requirements with ability to run reports with the ability to flag due dates.	4/28/2010  5/7/2010  4/01/2010  4/8/2010  6/30/2010	

*Accepted 5/11/10  
At Demand*

New York State Department of Health

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J1412	Continued From page 10  was signed by the appropriate health care provider. Specifically, according to the New York State Department of Health Memoranda (series 88-1) distributed on 01/04/88, the individuals who may complete the pre-employment physical examination are physicians, nurse practitioners, physicians assistants. Failure to ensure that employees receive an appropriate pre-employment physical has the potential to place the employee and the patient at risk for injury or infection with communicable disease. Employees # H, I, J, P  Examples are:  1. Employee I was initially contracted by the agency as an Occupational Therapist on 08/25/09. The record included 1 employee physical which had an incomplete date of 01/05.  2. Employee J was contracted by the agency as a social worker, and the record failed to contain any pre employment, or Followup up health assessment of the employee.  3. Employee P was initially contracted by the agency on 09/02/08. The 09/2008 pre-employment physical was signed by a nurse, and not by a physician.  The above findings were reviewed with the DPS on 03/11/10. No additional information was provided.	J1412	6. The DPS will be responsible to assure initial employment health requirements have been met. All present employees will be reviewed using the assistance of clerical support to ensure that current documentation of all requirements are contained within the record. These are to include per MCDOH policy required updated immunizations (PPD, MMR, Varicella, TD, Hep B series) and Initial physical exam signed by an MD/NP/PA.  7. The QA nurse/DPS will designate the yearly February monthly staff meeting to review immunizations, yearly physical update, infection control and HIPAA and provide update requirements to staff. The yearly March staff meeting will be used to monitor all records for compliance with completion of requirements.  8. The yearly April QA (quarterly meeting) report will reflect surveillance that all employee health and employment requirements have been met as reported by the designated QA nurse.	4/30/2010 ongoing  3/2011 and ongoing  4/2011 and ongoing
J1416	763.13(1)(i-iii) Personnel  763.13 Personnel.  The agency shall require the following of all personnel prior to assuming patient care duties:	J1416		

*Accepted Strike  
J. DeMartino*

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J1416	Continued From page 11  ..... (1) a certificate of immunization against rubella which means: (i) a document prepared by a physician, physician's assistant, specialist's assistant, nurse practitioner, licensed midwife or a laboratory possessing a laboratory permit issued pursuant to Part 58 of this Title, demonstrating serologic evidence of rubella antibodies, or (ii) a document indicating one dose of live virus rubella vaccine was administered on or after the age of twelve months, showing the product administered and the date of administration, and prepared by the health practitioner who administered the immunization, or (iii) a copy of the document described in subparagraph (i) or (ii) of this paragraph which comes from a previous employer or the school which the individual attended as a student; and  This Regulation is not met as evidenced by: Based on a review of 16 employee records, and interviews with the Director of Patient Services (DPS), there was no evidence in 3 records of immunization against rubella. Employees A, E, P  Failure of the agency to maintain complete employee records has the potential to compromise the health and safety of the patients served.  The above information was reviewed with the DPS on 03/11/10. No additional information was provided.	J1416	2. See J 1412 # 3 3. See J 1412 # 4 4. See J 1412 # 5  <i>Accepted 5/11/10</i> <i>SP [Signature]</i>	4/1/2010 5/13/2010 6/30/2010	
J1420	763.13(2)(i-iv) Personnel	J1420			

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J1420	<p>Continued From page 12</p> <p>763.13 Personnel.</p> <p>The agency shall require the following of all personnel prior to assuming patient care duties:</p> <p>....</p> <p>(2) a certificate of immunization against measles for all personnel born on or after January 1, 1957, which means:</p> <p>(i) a document prepared by a physician, physician's assistant, specialist's assistant, nurse practitioner, licensed midwife or a laboratory possessing a laboratory permit issued pursuant to Part 58 of this Title, demonstrating serologic evidence of measles antibodies; or</p> <p>(ii) a document indicating two doses of live virus measles vaccine were administered with the first dose administered on or after the age of 12 months and the second dose administered more than 30 days after the first does but after 15 months of age showing the product administered and the date of administration, and prepared by the health practitioner who administered the immunization; or</p> <p>(iii) a document, indicating a diagnosis of the person as having had measles disease prepared by the physician, physician's assistant/specialist's assistant, licensed midwife or nurse practitioner who diagnosed the person's measles; or</p> <p>(iv) a copy of the document described in subparagraph (i), (ii) or (iii) of this paragraph which comes from a previous employer or the school which the person attended as a student;</p> <p>This Regulation is not met as evidenced by: Based on a review of 16 employee records reviewed, and interviews with the DPS, there is no evidence in 2 records the personnel record included any evidence of immunization against</p>	J1420			

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J1420	Continued From page 13  measles, and the employees birthdate is unknown. Employees # E, P  Failure of the agency to maintain complete employee records has the potential to compromise the health and safety of the patients served.  The above findings were reviewed with the Director of Patient Services on 03/11/10. No additional information was provided.	J1420			
J1424	763.13(4) Personnel  763.13 Personnel.  The agency shall require the following of all personnel prior to assuming patient care duties: .... (4) ppd (Mantoux) skin test for tuberculosis prior to assuming patient care duties and no less than every year thereafter for negative findings. Positive findings shall require appropriate clinical follow-up but no repeat skin test. The agency shall develop and implement policies regarding follow-up of positive test results;  This Regulation is not met as evidenced by: Based on a review of 16 employee records, and interviews with the Director of Patient Services (DPS), there was no evidence in 5 records of proof of ppd testing within the past 12 months. Employees A, B, C, D, F  Failure of the agency to maintain complete employee records has the potential to compromise the health and safety of the patients served.	J1424	J1424 763.13 (4) Personnel  1. Employees A,B,C, D and F received PPD testing on 3/25/2010. 2. Review and revise employee health policy to reflect that all employees and contract staff must receive PPD testing/ assessment of result prior to assuming job duties with yearly retest. Present policy to PAB. 3. Business process matrix will be completed for tracking employee/contract requirements including health, immunization, license, certifications, mandatory trainings, and performance appraisals. This process was initiated on 4/8/2010. 4. Develop and implement collaboratively with the IT department a secure data base for tracking employee requirements with ability to run reports with the ability to flag due dates. 5. The QA nurse/DPS will designate the yearly February monthly staff meeting to review immunizations, yearly physical update, infection control and HIPAA and provide update requirements to staff. The yearly March staff meeting will be used to monitor. 6. The yearly April QA (quarterly meeting) report will reflect surveillance that all employee health and employment requirements have been met as reported by the designated QA nurse.	3/25/2010  4/28/2010  5/13/2010  6/30/2010  ongoing  ongoing	

*Accepted 5/21/10*  
*A. Demas*



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J1424	Continued From page 14  Examples are as follows:  1. The record for employee F failed to include any ppd testing.  2. The record for employee B failed to include any ppd testing during the past 12 months. Specifically, the last ppd testing was performed on 02/27/09.  3. The record for employee C failed to include any ppd testing during the past 12 months. Specifically, the last ppd testing was performed on 02/27/09.  The above information was reviewed with the DPS on 03/11/10. No additional information was provided.	J1424			
J1444	763.13(h) Personnel  763.13 Personnel  (h) that personnel records include, as appropriate, records of professional licenses and registrations; verifications of employment history and qualifications for the duties assigned; signed and dated applications for employment; records of physical examinations and health status assessments; performance evaluations; dates of employment, resignations, dismissals, and other pertinent data, provided that all documentation and information pertaining to an employee's medical condition or health status, including such records of physical examinations and health status assessments shall be maintained separate and apart from the non-medical personnel record information and shall be afforded the same confidential treatment given	J1444	J1444 763.13 (h) Personnel  1. The DPS and DHD met with the personnel office on 3/28/2010 to discuss personnel record information and maintenance.  2. A clerical staff member will be assigned to separate medical and non-medical information in the in personnel file records.  3. Review current county personnel record policy and develop an agency specific policy as needed to comply with 763.13 to include contents required in the personnel file and contents required in the division file as well as who will be designated to maintain this information. Submit policy to PAB/PAC for approval.	3/28/2010  4/30/2010  5/15/2010	

*Accepted 5/11/10.  
St. De Martin*

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J1444	Continued From page 15  patient medical records under section 763.7 of this Part;  This Regulation is not met as evidenced by: In 16 personnel records reviewed, and interviews with the Director of Patient Services (DPS) evidence is lacking in 16 records (100%) that physical examinations / health status/ immunization assessments are maintained separate and apart from the non-medical personnel record information. Specifically, all information is being maintained in the same personnel record. Employees A - P  Failure of the agency to separate all employee medical and personnel records has the potential for employee records to not be treated in a confidential manner.  The above information was reviewed with the DPS on 03/11/10. No additional information was provided.	J1444		
J1456	763.13(k) Personnel  763.13 Personnel  (k) that an annual assessment of the performance and effectiveness of each person is conducted and documented in writing, including at least one home visit to observe performance if the person provides services in the home; and  This Regulation is not met as evidenced by: Based on a review of 16 employee records	J1456	J1456 763.16 (k) Personnel  1. Employees A,B,C,G,H have completed evaluations on file in personnel. Employees D,F,J and P will have completed observational home visit and performance evaluations done by their immediate supervisor. Employee E is no longer employed by MCDOH. A new therapist has been hired in her place as of 4/1/2010  2. A review of existing departmental appraisal policy will be done with the DHD/ DPS/ADPS and PT Coordinator.	6/30/2010  6/30/2010

*Accepted 1/21/10  
St. Dominic*

New York State Department of Health

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J1456	Continued From page 16  reviewed, and interviews with the Director of Patient Services (DPS), 10 records failed to include a completed evaluation of the employees performance within the past 12 months. Employees: A - H, J, P  Failure of the agency to maintain complete employee records has the potential to compromise the health and safety of the patients served.  The above information was reviewed with the DPS on 03/11/10. No additional information was provided.	J1456	3. Business process matrix will be completed for tracking employee/contract requirements including health, immunization, license, certifications, mandatory trainings, and performance appraisals. This process was initiated on 4/8/2010. 4. Develop and implement collaboratively with the IT department a secure data base for tracking employee requirements with ability to run reports with the ability to flag due dates. 5. The QA nurse will be responsible for monitoring the above data base, notifying employees of requirement deficiencies and reporting to the PAB/PAC/DPS any barriers to maintaining current records. The PAB/PAC will be asked for recommendations if barriers cannot be resolved. The first report will be given at the July 2010 PAB/PAC meeting.	5/13/2010
J1460	763.13(I) Personnel  763.13 Personnel  (I) that all personnel receive orientation to the policies and procedures of the agency operation, in-service education necessary to perform his/her responsibilities and continuing programs for development and support.  This Regulation is not met as evidenced by: Based on a review of 16 personnel records, and interviews with the Director of Patient Services (DPS), there is no evidence in 11 record, where the employee was hired within the past 3 years, that the employee received an initial orientation to the policies and procedures of the agency necessary to perform his/her responsibility. Employees # A, C - L, P  Failure to orient new employees to the agency's policies and procedures has the potential for the provision of care by staff which is not safe, and	J1460	J 1460 763.13 (I) Personnel 1. Review and revise CHHA orientation policy to include parties responsible for assuring that employees complete initial orientation to agency policies and procedures. Submit revised policies to the PAB for approval.  2. Review and revise CHHA orientation checklist/verification sign off sheet to assure completion and documentation of all divisional policies and procedures and present to CHHA supervisory staff.	6/30/2010  7/21/2010  5/1/2010

*Accepted 5/18/10  
J. Demanda*

New York State Department of Health

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J1460	Continued From page 17  potentially harmful to the patients, and may result in possible agency wide negative outcomes.  The above findings were reviewed with the DPS. No additional information was provided.	J1460		
J1476	763.13(m)(1)(iii) Personnel  763.13 Personnel  (m) (1) that a program is implemented for the prevention of personnel or patients/clients becoming exposed to significant risk body substances which could put them at significant risk of HIV or other blood-borne pathogen infection as defined in sections 63.1 and 63.9 of this Title. Such a program shall include  ..... (iii) training at the time of employment and yearly personnel development programs on the use of protective equipment, preventive practices, and circumstances which represent a significant risk for all personnel whose job related tasks involve, or may involve, exposure to significant risk body substances;  This Regulation is not met as evidenced by: Based on a review of 16 employee records, and interview with the Director of Patient Services (DPS), there is no evidence in 5 records the employees participated in any inservices for universal precautions for infection control in the past 12 months. Employees A, B, E, G, P  Failure of the agency to ensure that all employees participate in a program for the prevention of personnel and patients becoming exposed to significant risk body substances puts	J1476	J1476 763.13 (m)(1) (iii) Personnel  1. Employees A, B, E, G, and P completed infection control/blood borne pathogen training on 3/24 using agency self-study syllabus.  2. Review infection control/blood borne pathogen policy regarding annual training with supervisory staff.  3. Business process matrix will be completed for tracking employee/contract requirements including health, immunization, license, certifications, mandatory trainings, and performance appraisals. This process was initiated on 4/8/2010.  4. Develop and implement in collaboration with the IT department a secure data base for tracking employee requirements with ability to run reports with the ability to flag due dates.  5. The QA nurse will be responsible for monitoring the above data base, notifying employees of requirement deficiencies and reporting to the PAB/PAC/DPS any barriers to maintaining current records. The PAB/PAC will be asked for recommendations if barriers cannot be resolved. The first report will be given at the July 2010 PAB/PAC meeting.	3/24/2010     3/24/2010   5/30/2010  6/30/2010  7/21/2010

*Accepted for LCO  
H. Demanin*

New York State Department of Health

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NAME OF PROVIDER OR SUPPLIER  MADISON CO PH DEPT CHHA		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 605 NORTH COURT STREET WAMPSVILLE, NY 13163			
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J1476	Continued From page 18  both the employee and patients at risk of HIV or other blood-borne pathogen infection.  The above information was reviewed with the DPS on 03/11/10, no additional information was provided.	J1476			



## MADISON COUNTY DOH HEALTH COMMERCE POLICY

**PURPOSE:** The Health Information Network (HIN) provides access to the Health Provider Network (HPN) and Health Alert Network (HAN) that assures notification of public health alerts in a secure, and confidential manner. Together the networks are known as E-Commerce or 'Commerce'.

The Certified Home Health agency, Long Term Home Health Care Program and Diagnostic and Treatment Centers Article 28 programs are required to have a Health Provider Network (HPN) account as health agencies having business responsibilities with the New York State Department of Health.

**DATE ADOPTED:**

**REVISED:**

**POLICY:** **Overall Security:**

The Madison County Health Department (MCDOH) hereafter referred to as the 'Agency' is responsible for the security of data located on, or transported over its network. The 'Agency' is responsible for validating the users who need access to the network, physical security of the computers on the network, and security of removable data.

The 'Agency' will immediately notify the New York State Department of Health if the status of any authorized user changes due to duty reassignment, or change in employment status by calling 1-866-529-1890 or by sending an e-mail to: [www.hinhpn@health.state.ny.us](mailto:www.hinhpn@health.state.ny.us)

**Disclosure of Data:**

Employees of the 'Agency' who have acquired knowledge of personal health data that originated from the 'Commerce' may not disclose this data to any other person unless that person is authorized to view that information and requires it for the performance of an official duty.

**Responsibility:**

The Director of Health (hereafter referred to as the Administrator), serves in the role of HIN/HPN Coordinator (HINC/HPNC), Organizational Security Coordinator (OSC), and HIN/HPN User. The Administrator agrees to abide by the

## MADISON COUNTY DOH

### HEALTH COMMERCE POLICY

terms and conditions set forth in the HIN/HPN User Security and Use Policy.

The Administrator has designated the personnel in the positions of Health Educator, Confidential Secretary, and Account Clerk II to serve in the role of HIN/HPN Coordinators (HINC/HPNC). They will be accountable for execution of the roles and responsibilities as outlined in the HIN/HPN User Security and Use Policy (see attached) The Administrator is responsible for actions of either HINC/HPNC if they are remiss in their duties.

The HINC/HPNCs are responsible for giving a HIN/HPN User Security and Use Policy to employees of the department requiring access to the HIN/HPN. The HINC agrees to the terms of the HIN User SAUP and is bound to enforce the terms and conditions of the agreement on behalf of the HIN/HPN users employed by the department or affiliated with it. The HINC/HPNCs are responsible for the action of any employee in regard to compliance with HIN/HPN policies. Every HINC/HPNC will have an active HIN/HPN account, and the Agency will assure that the HINC/HPNCs are bound by the terms and conditions of the HIN/HPN User SAUP. The Agency agrees to ensure that the HINC/HPNCs routinely access the HIN and HPN and carry out the required duties and responsibilities in a timely manner. The Agency will replace any HINC/HPNC that does not fulfill their duties upon its own discovery or upon notification by the New York State Department of Health.

(See NYS HIN/HPN Organization Security and Use Policies and NYSDOH HIN/HPN Individual User Security and Use Policy attached.

#### **Access and Data Security:**

Users are responsible to ensure that their PIN number and password are kept confidential and in a secure place.

No employee may share a HIN or HPN account or use an account assigned to another employee. No employee may share their codes, ids, or passwords with another.

User privileges will be revoked on the **first violation of this rule**. Upon termination of employment, user will cease to use their codes, etc. and the 'Agency' will make the proper notification of change in employment status.

Users will not access data to which they are not entitled. If the HIN or HPN user downloads data from the server, the user is responsible to secure the data from theft or disclosure. Data obtained from the HIN/HPN or other 'Commerce' access may only be utilized for those areas that are authorized by the New York State Department of Health and in ways that are consistent with public health functions and state laws.

#### **Disclosure of Data:**

Health data from 'Commerce' is protected under Federal, and State confidentiality

## **MADISON COUNTY DOH HEALTH COMMERCE POLICY**

laws and by NYSDOH policies and procedures. You may not disclose information obtained from 'Commerce' to any other person except under the following limited circumstances:

1. The person is explicitly authorized to view that information.
2. The person requires that information to perform an official task.
3. The person has signed and filed a HIN Security and Use Policy agreement with NYSDOH.

### **Investigations:**

The HIN/HPN Coordinator will notify the NYSDOH immediately upon discovery of a suspected or confirmed breach of security protocol by electronic systems on the HIN/HPN or by calling 1-866-529-1890. (Within at least twenty-four (24) hours).

### **Violations:**

Violations of the above policies will result in loss of HIN/HPN access on the first instance of known violation. Any unauthorized use or abuse of these privileges will be reported to the NYSDOH and may result in any appropriate imposition of monetary penalty or criminal prosecution as per Federal and State Statutes.

### **Health Provider Network Access and Reporting Requirements:**

As per Title X, Section 400.10, the 'Agency' will maintain a separate Health Provider Network (HPN) account for the Certified Home Health Care Agency, Long Term Home Health Care Services and the Diagnostic and Treatment Center Article 28 services. The 'Agency' will utilize the same personnel as indicated in the HINC section for the duties of HPN coordinators and provide emergency contact information in the 'Agency's' HPN Communication Directory for 24 hours per day and 7 days per week emergency communications.

The 'Agency' will maintain a HPN Communications Directory with the names, addresses, home and cell phone numbers for all HPN Coordinators and agency staff with a role in the directory. Changes reflecting general or personnel role information will be reported as it occurs and at a minimum, on a monthly basis.

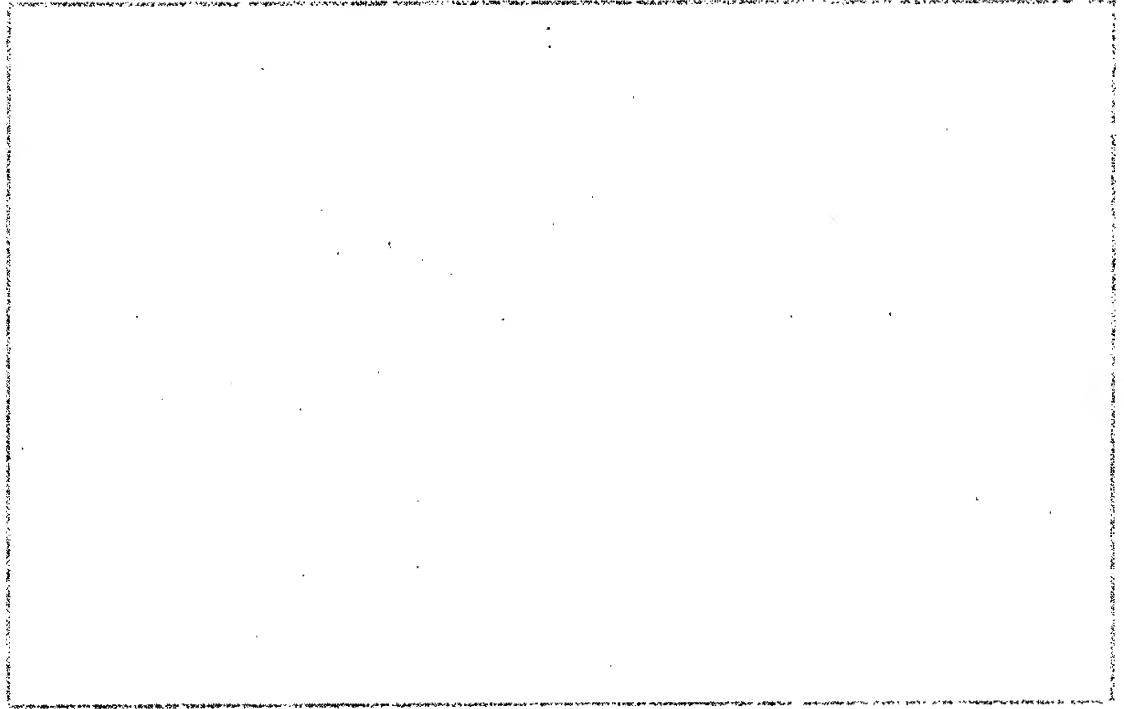
### **Maintenance of Agencies HPN Account:**

The 'Agency' will maintain its HPN Account assuring there are sufficient HPN coordinators to permit HPN individual user application and assign sufficient staff users to ensure rapid response to requests for information by the NYSDOH.

The 'Agency' agrees to adhere to the requirements of the HPN user contract and to maintain security as indicated in the Access and Security Section of this policy.



# MADISON COUNTY DOH HEALTH COMMERCE POLICY



Patient	#	NYSDOH Survey Completed 3/17/10 Plan of Care Citation/Corrective Action Flow Sheet	Responsible person	Date Completed
Patient 1,2,7,8,9,10,12,15 Discharged		ADPS to meet individually with PCN responsible for corrective actions.  All findings will be reviewed with the primary care nurse and documentation addendums/ corrections as appropriate will be completed by 4/30/10.	Karen Crawford RN ADPS  Martha Phillips RN ADPS	4/30/10
#5		Need for nutritional consult/done 3/30/10 by Lisa Yerah RD  Need for follow up with MSW or Mental Health-coordination with MD/interdisciplinary conference with MSW/RD to be scheduled and completed by 5/7/10.  POC for suprapubic catheter care and MD order for caregiver to manage SP catheter/orders for caregiver to manage suprapubic catheter/teaching and demo re-demo of replacement/irrigation of SP catheter to be implemented by PCN by 5/3/10  Repositioning schedule for tx and prevention of decubitus/repositioning schedule by caregiver of q2hr while in bed and in wheelchair added to the POC-suggestion to caregiver to keep a log of schedule to ensure compliance  Plan of care for heel ulcer/heel ulcer has healed/nurse counseled re: importance of having treatment plan on POC  Quadriplegic diagnosis not on care plan/ ICD 9 added Failure to document-notification of the physician of multiple elevated	J Hurst	3/30/10  5/7/10  5/3/10  3/17/10  4/19/10  3/17/10  3/17/10
			J Myers	

#6	<p>BP readings via telehealth/ revised policy in place for trending sheets to be faxed to the MD weekly and prn – pt no longer on tele-monitoring. PCN counseled on importance of timely notification/documentation of vital signs readings outside of parameters.</p> <p>Failure to report 17# weight loss in 6 day period</p> <p>Failure to designate BS parameters and plan for increased blood sugar</p> <p>Medication management states no injection/pt was on an injectable medication/ADPS met with PCN and counseled on importance of the timely notification of physician in regards to weight loss or discrepancy in weight on different scales/importance of accurate answer to MO 2040 as per medication reconciliation as well as the importance of documentation of BS parameters on the 485 as they were taught to the patient as part of diabetic teaching. This patient was hospitalized and a resumption of care done on 4/11/10. Weight parameters/notification and BS testing/parameters/S&amp;S of hypo/hyperglycemia and plan for treatment are included in the POC.</p>	RN monitoring telehealth	3/17/10
#3	<p>Failure to document notification of the physician of multiple abnormal SPO2 level readings via telehealth/ revised policy in place for trending sheets to be faxed to the MD weekly and prn</p> <p>Failure in appropriate pain assessment/documentation/teaching re: patient's reluctance to take pain meds for fear of constipation /ADPS and PCN met regarding the importance of establishing a bowel regimen with MD order for bowel medication if necessary to allow patient to maximize use of pain medication for relief. Staff training will be presented on pain assessment and documentation by 6/1/10.</p> <p>Failure of RN case manager to maintain ordered frequency and failure to document a weekly wound measurement.</p> <p>Failure to report low BP to MD on 2/16/10 visit</p> <p>Failure to report change in pain status on 2/16/10 visit</p> <p>Failure to document if patient had knowledge in correctly applying and changing pain patch correctly. / ADPS and PCN K Reeder met</p>	B Babcock RN monitoring telehealth	4/30/2010
# 18		K Reeder	

		regarding above issues and PCN counseled on the importance of timely notification of MD on V/S abnormality and change in pain status. Staff training will be presented on pain assessment and documentation by 6/1/10.		
#13		Failure of the RN to document that an assessment was done at the time of HHA supervision/addressed with PCN who states that patient refused assessment other than vital signs saying that she was to fatigued-PCN was counseled that documentation should have stated that patient refused head to toe physical assessment at visit. Unable to submit addendum note as patient has been discharged.	S. Conklin	4/20/10
#19		No noted assessment visit 2/10 - 3/10/late entry note for 2/24/10 documenting skilled nurse visit on that date.	N. Orth	3/17/10



MADISON COUNTY

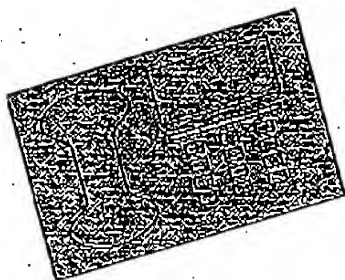
## DEPARTMENT of HEALTH

Working to build a healthy community

PO Box 605, Wampsville, NY 13163 ~ Phone (315) 366-2361

Eric Faisst, Director of Public Health

Dr. John B. Endres, President of Board of Health

TO FAX: 477-8583 DATE: 5/21/10CONFIDENTIALITY NOTICE

This facsimile transmission is intended only for the use of the individual or entity to which it is addressed and may contain confidential information belonging to the sender which is protected by the Caseworker/Client privilege or any other privileged communication. If you are not intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited. If you have received this transmission in error, please immediately notify us by telephone to arrange for the return of these documents. Thank you.

DELIVER TO: Helene DeMandinoSENT BY: V Parrott# OF PAGES INCLUDING COVER: 5SUBJECT: Changes APN policy - see page 3  
of the policy.Environmental Health Division  
Phone 366-2526, Fax 366-2207Home Care Division  
Phone 366-2361, Fax 366-2566Prevent Division  
Phone 366-2361, Fax 366-2847



## MADISON COUNTY DOH HEALTH COMMERCE POLICY

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**Responsibility:**

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The Administrator has designated the personnel in the positions of Health Educator

## **MADISON COUNTY DOH HEALTH COMMERCE POLICY**

and Confidential Secretary to serve in the role of HIN/HPN Coordinators (HINC/HPNC). They will be accountable for execution of the roles and responsibilities as outlined in the HIN/HPN User Security and Use Policy (see attached) The Administrator is responsible for actions of either HINC/HPNC if they are remiss in their duties.

The HINC/HPNCs are responsible for giving a HIN/HPN User Security and Use Policy to employees of the department requiring access to the HIN/HPN. The HINC agrees to the terms of the HIN User SAUP and is bound to enforce the terms and conditions of the agreement on behalf of the HIN/HPN users employed by the department or affiliated with it. The HINC/HPNCs are responsible for the action of any employee in regard to compliance with HIN/HPN policies. Every HINC/HPNC will have an active HIN/HPN account, and the Agency will assure that the HINC/HPNCs are bound by the terms and conditions of the HIN/HPN User SAUP. The Agency agrees to ensure that the HINC/HPNCs routinely access the HIN and HPN and carry out the required duties and responsibilities in a timely manner. The Agency will replace any HINC/HPNC that does not fulfill their duties upon its own discovery or upon notification by the New York State Department of Health.

(See NYS HIN/HPN Organization Security and Use Policies and NYSDOH HIN/HPN Individual User Security and Use Policy attached.

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1. The person is explicitly authorized to view that information.

## MADISON COUNTY DOH HEALTH COMMERCE POLICY

2. The person requires that information to perform an official task.
3. The person has signed and filed a HIN Security and Use Policy agreement with NYSDOH.

### **Investigations:**

The HIN/HPN Coordinator will notify the NYSDOH immediately upon discovery of a suspected or confirmed breach of security protocol by electronic systems on the HIN/HPN or by calling 1-866-529-1890. (Within at least twenty-four (24 hours).

### **Violations:**

Violations of the above policies will result in loss of HIN/HPN access on the first instance of known violation. Any unauthorized use or abuse of these privileges will be reported to the NYSDOH and may result in any appropriate imposition of monetary penalty or criminal prosecution as per Federal and State Statutes.

### **Health Provider Network Access and Reporting Requirements:**

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The 'Agency' will maintain a HPN Communications Directory with the names, addresses, home and cell phone numbers for all HPN Coordinators and agency staff with a role in the directory. Changes reflecting general or personnel role information will be reported as it occurs and at a minimum, on a monthly basis by HPN/HIN coordinators.

### **Maintenance of Agencies HPN Account:**

The 'Agency' will maintain its HPN Account assuring there are sufficient HPN coordinators to permit HPN individual user application and assign sufficient staff users to ensure rapid response to requests for information by the NYSDOH. Public health educators and the confidential secretary are assigned as HPN coordinators and are responsible for all responsibilities listed in above sections. *added*

The 'Agency' agrees to adhere to the requirements of the HPN user contract and to maintain security as indicated in the Access and Security Section of this policy.



**MADISON COUNTY DOH**  
**HEALTH COMMERCE POLICY**



# STATE OF NEW YORK DEPARTMENT OF HEALTH

Central NY Region

217 South Salina Street

Syracuse, New York 13202

Richard F. Daines, M.D.  
Commissioner

James W. Clyne, Jr.  
Executive Deputy Commissioner

December 10, 2010

Roderick Torrence, CEO  
Winds of Agape Home Care Agency  
1414 Grant Boulevard  
Syracuse, NY 13208

Agency: Winds Of Agape Home Care Agency  
License #: 1090L001  
Type of Survey: Complaint Investigation  
Complaint # NY00090535  
Event ID #: UEPS11  
Survey Exit Date: December 9, 2010

**Plan of Correction Due Date: December 27, 2010**

Dear Mr. Torrence:

Enclosed is a copy of the Statement of Deficiency (SOD) report resulting from the Article 36 offsite complaint investigation conducted by staff from this office. This is being sent to you in your capacity as the Operator of this agency. You are responsible for the agency's compliance with all applicable rules and regulations. A copy of the SOD report is being forwarded to the agency's Administrator.

A detailed Plan of Correction (POC) must be completed and returned to this office by the above referenced date. The POC should be documented on the right side of the SOD report sent to the administrator and must be **signed and dated at the bottom of the first page**. A copy should be retained for the records of the agency.

Your POC must contain the following for each deficiency cited:

- What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;

- What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and
- The date for the correction and the title of the person responsible for correction of each deficiency.

This office will review your POC, if your POC is unacceptable, staff from our office will contact you to discuss the items involved.

Please contact Helene DeMartino at (315) 477-8532 with any questions.

Sincerely,

*Helene DeMartino for Lynn Shannon*

Lynn C. Shannon  
Home and Community Based Program Manager

LCS/mls

cc: Laverne Torrence, Administrator

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0357A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/09/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>WINDS OF AGAPE HOME CARE AGENCY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1414 GRANT BOULEVARD SYRACUSE, NY 13208</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 000	Initial Comments  On 08/23/10 the New York State Department of Health (DOH) received a complaint (Complaint # NY 000 90535) regarding patient care being provided by the Licensed Home Care Services Agency (LHCSA).  On 08/24/10 the DOH requested the LHCSA conduct a self investigation.  Despite two submissions by the LHCSA of a self investigation, and assistance from the DOH, the LHCSA was unable to conduct a thorough and objective investigation of the complaint.  This statement of deficiencies is the result of an off site investigation conducted by the DOH due to the LHCSA's inability to conduct a self investigation, identify and correct agency problems, adequately supervise home health aides.	H 000			
H1002	766.9(a) Governing authority  Section 766.9 Governing authority.  The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall:  (a) be responsible for the management and operation of the agency;  (b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations.  This Regulation is not met as evidenced by:	H1002			

Office of Health Systems Management / Office of Long Term Care

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

Version NYS 11/03/2010 UEPS11

If continuation sheet 1 of 6

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  LC0357A	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/09/2010
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H1002	<p>Continued From page 1</p> <p>Based on a review of the agency's self investigation of a complaint, and documentation submitted by the patient; and interviews with the the Director of Patient Services (DPS), and the patient's consumer directed aide; there is no evidence the DPS understood her responsibility to self identify, and resolve problems within the agency by objectively conducting complaint investigations</p> <p>Failure of the agency to understand their responsibility to self identify and correct problems within the agency has the potential for unmet patient's needs, and possible negative patient outcomes.</p> <p>Evidence is as follows:</p> <p>Patient #1 is a [REDACTED] with a primary diagnosis of brain injury, and a secondary diagnosis of paralysis. On 08/24/10 the NY State Department of Health sent a letter to the agency requesting the agency investigate a complaint that alleged that on 08/19/10 a Home Health Aide (HHA) employed by the agency, failed to follow the plan of care. Specifically, the patient had requested that the agency's HHA clean her more thoroughly following a bowel movement, and that the HHA had refused. Despite assistance from the DOH, the agency DPS was unable to perform an effective self investigation of the complaint. As a result the DOH was compelled to investigate and clarify the facts of the incident for the DPS. Despite this assistance from the DOH, and direction from the DOH to continue the self investigation, the DPS was unable to conduct an objective self investigation and identify that a problem existed within the agency.</p>	H1002		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0357A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/09/2010</b>
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H1002	<p>Continued From page 2</p> <p>Specifically:</p> <ul style="list-style-type: none"> <li>- On 09/13/10 the DPS submitted a self investigation to the DOH which failed to substantiate the complaint. Although the DPS interviewed the agency's HHA, the DPS failed to: identify the correct date of the alleged incident was 08/18/10, and not 08/19/10, identify who the correct consumer directed aide was who followed the agency's HHA on 08/18/10, interview the consumer directed aide. As a result the DOH was compelled to investigate and clarify the facts of the incident for the DPS.</li> <li>- On 10/01/10 the surveyor received and reviewed a typed statement from the patient, who clarified that it was on 08/18/10 that she had a bowel movement while in the care of the agency's HHA. She stated that the wipe that the HHA used was very soiled, and so she (the patient) requested that the HHA wipe her again, and that the HHA had refused. The statement also clarified that the name of the consumer directed aide, who relieved the agency's HHA in question, was different from the name given to the DOH during the complaint intake process.</li> <li>- On 10/13/10, the surveyor interviewed the correct consumer directed aide, who stated: her shift started on 08/18/10 at 7:30 AM, which was immediately following the agency's HHA's shift; soon after she arrived, the patient communicated that she had to void; following the patient's void, the consumer directed aide cleaned the patient and noticed she had old fecal material between her buttocks; 5 wipes were required to adequately clean the remaining fecal material, it appeared that it had been there "awhile", and that it had</li> </ul>		H1002		

New York State Department of Health

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NAME OF PROVIDER OR SUPPLIER  <b>WINDS OF AGAPE HOME CARE AGENCY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1414 GRANT BOULEVARD SYRACUSE, NY 13208</b>		
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H1002	<p>Continued From page 3</p> <p>been partially cleaned.</p> <p>Additionally, the consumer directed aide stated to the surveyor the patient always told her when she needed to have a bowel movement, and never has had any bowel leakage, or incontinence.</p> <p>The aide provided a written statement to the surveyor which documented the above facts.</p> <p>- On 10/19/10 the surveyor contacted the DPS and notified the DPS of the correct date of the incident (10/18/10), and the correct name of the consumer directed aide. The surveyor advised the DPS that the complaint was substantiated in that both the patient and the consumer directed aide gave the same information indicating that the agency's HHA failed to adequately cleanse the patient following a bowel movement, the bowel movement had been there for awhile, and had only been partially cleaned.</p> <p>Additionally, the surveyor advised the DPS that the consumer directed aide was amenable to being interviewed by the DPS, and directed the DPS to continue to investigate and resubmit a revised self investigation now that she was given the correct information.</p> <p>- On 10/22/10 the DPS submitted a revised self investigation and documented that although she had interviewed the consumer directed aide, who had confirmed the facts as stated to the surveyor, she (the DPS) was unable to substantiate the complaint.</p> <p>Although the DOH assisted the DPS with the self investigation by obtaining and providing the</p>	H1002		

New York State Department of Health

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H1002	<p>Continued From page 4</p> <p>correct information to her, the DPS was still unable to objectively investigate and substantiate the complaint. Specifically:</p> <ul style="list-style-type: none"> <li>- Although the surveyor clarified the correct identity of the consumer directed aide, and the DPS interviewed her, the DPS documented she could not substantiate the complaint because the consumer directed aide originally identified was incorrect.</li> <li>- Although the DPS interviewed the correct consumer directed aide, the DPS failed to confirm with the aide that the bowel movement had been there awhile and partially cleaned, and that the patient was always aware of when she was about to have a bowel movement, and was never incontinent of stool.</li> <li>- The DPS documented she could not substantiate the complaint because the family had refused to speak to her, however, the surveyor communicated to the DPS specifically what the patient's concerns were.</li> <li>- The DPS documented she could not substantiate the complaint because the family never voiced a complaint directly to the agency. The DPS failed to identify that it is a patient right to file a complaint directly with the NY State Department of Health, and the agency was responsible for fully investigating all complaints, whether or not voiced directly to the agency.</li> <li>- The DPS stated to the surveyor on 10/19/10 that the patient was "very particular about the personal care she received", the consumer directed aide was only in her mid twenties, and the agency HHA was a more mature women.</li> </ul>	H1002		



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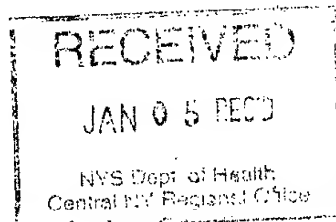
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H1002	<p>Continued From page 5</p> <p>The DPS failed to identify the patient was vulnerable, had a right to be particular about the personal care she received, the ages of the caregivers were not relevant to the investigation, and that the HHA is obligated to implement the plan of care.</p> <p>Despite the agreement of both the patient, and the consumer directed aide, that the agency's HHA had refused to properly clean the patient following a bowel movement, the DPS failed to objectively investigate the complaint, identify that the complaint was valid, and develop an action plan to avoid a reoccurrence of a similar problem.</p>	H1002		



# Winds of Agape, Inc.

*Winds of Hope...Winds of Support...Winds of Agape*

January 4, 2011



Ms. Lynn Shannon  
New York State Department of Health  
Central New York Regional Office  
217 South Salina St.  
Syracuse, New York 13208

Dear Lynn Shannon,

Please find enclosed request of documentation on Complaint number: NY 000 90535.  
Please call (315) 425-0547, if more documentation is needed on this case.

Respectfully submitted,

Roderick L. Torrence  
*Executive Director*

LaVerne Torrence, R.N., M.S.N.,  
*Administrator*

LT/tat

cc: Helene DeMartino

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*Roderick L. Torrence, Executive Director*

*LaVerne Torrence, R.N., M.S.N., Administrator*

**NEW YORK STATE DEPARTMENT OF HEALTH  
HOME CARE COMPLAINT INVESTIGATION PROGRAM**

**AGENCY COMPLAINT INVESTIGATION FORM**

**COMPLAINT:** NY00090535

**AGENCY NAME:** Winds Of Agape Home Care Agency

**DATE SENT:** August 24, 2010

**DATE DUE:** September 8, 2010

**PATIENT NAME (if applicable):** Jamie Hubbard

**AGENCY INVESTIGATOR ASSIGNED:** \_\_\_\_\_

**INVESTIGATOR TELEPHONE #:** \_\_\_\_\_

**ALLEGATIONS:**

(Summarize allegations)

**1. Resident/Patient/Client Rights**

Agency HHA (Karen) failed to treat patient Jamie Hubbard with respect and dignity. Specifically, the HHA working on the night shift (11 pm - 7 am) on 8/19/2010 told the patient at least twice during the shift "I am sick of working for you." The HHA responded to the patient in this manner when the patient asked to be repositioned in bed.

**2. Quality of Care/Treatment**

Agency HHA (Karen) failed to follow the plan of care. Specifically, the HHA failed to clean the patient sufficiently after the patient had a bowel movement. The patient asked the HHA to wipe her and the HHA refused. The patient asked the aide on the next shift to wipe her. The relief aide told the patient she was very soiled, and the aide had to wipe the patient three times.

New York State Department of Health

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H 000	<p>Initial Comments</p> <p>On 08/23/10 the New York State Department of Health (DOH) received a complaint (Complaint # NY 000 90535) regarding patient care being provided by the Licensed Home Care Services Agency (LHCSA).</p> <p>On 08/24/10 the DOH requested the LHCSA conduct a self investigation.</p> <p>Despite two submissions by the LHCSA of a self investigation, and assistance from the DOH, the LHCSA was unable to conduct a thorough and objective investigation of the complaint.</p> <p>This statement of deficiencies is the result of an off site investigation conducted by the DOH due to the LHCSA's inability to conduct a self investigation, identify and correct agency problems, adequately supervise home health aides.</p>	H 000	<p><u>Plan of Correction Completed</u></p> <p>Winds of Agape under DPS began self-investigation of NY 00090535 on 8/20/2010 to 9/13/2010 and 10/12/2010 to present – 1/3/11 investigation was impeded by the refusal of client, family and staff to be interviewed by Winds of Agape Home Care agency. Winds of Agape Home Care Agency will begin corrective action immediately for any patients found to have affected by any deficient practice.</p> <p>Interviews will be conducted of client, family, staff involved in each complaint, aide involved. Corrective measures, in-services, counseling and possible suspension will occur as needed.</p>	Completed 12/31/2010 Responsible Person: L. Torrence
H1002	<p>766.9(a) Governing authority</p> <p>Section 766.9 Governing authority.</p> <p>The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall:</p> <p>(a) be responsible for the management and operation of the agency;</p> <p>(b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations.</p> <p>This Regulation is not met as evidenced by:</p>	H1002	<p><u>Plan of Correction Completed</u></p> <p>The Governing Authority of Winds of Agape Home Care Agency and Quality Assurance Committee are responsible meets quarterly for management and operation of the agency and ensure compliance of all home care services in compliance with all federal, state, and local rules and regulations.</p>	Completed 1/3/2010 Responsible Person: L. Torrence Admin.

Office of Health Systems Management / Office of Long Term Care

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

Version NYS 11/03/2010 UEPS11

(X8) DATE

(Continuation sheet 1 of 6)

*Unacceptable per Helene Demartino*

*LCS 1/11*

*that COGAP provided statements - which is consistent with the top of the page*

New York State Department of Health

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H1002	<p>Continued From page 1</p> <p>Based on a review of the agency's self investigation of a complaint, and documentation submitted by the patient; and interviews with the the Director of Patient Services (DPS), and the patient's consumer directed aide; there is no evidence the DPS understood her responsibility to self identify, and resolve problems within the agency by objectively conducting complaint investigations</p> <p>Failure of the agency to understand their responsibility to self identify and correct problems within the agency has the potential for unmet patient's needs, and possible negative patient outcomes.</p> <p>Evidence is as follows:</p> <p>Patient #1 is a [REDACTED] with a primary diagnosis of brain injury, and a secondary diagnosis of paralysis. On 08/24/10 the NY State Department of Health sent a letter to the agency requesting the agency investigate a complaint that alleged that on 08/19/10 a Home Health Aide (HHA) employed by the agency, failed to follow the plan of care. Specifically, the patient had requested that the agency's HHA clean her more thoroughly following a bowel movement, and that the HHA had refused. Despite assistance from the DOH, the agency DPS was unable to perform an effective self investigation of the complaint. As a result the DOH was compelled to investigate and clarify the facts of the incident for the DPS. Despite this assistance from the DOH, and direction from the DOH to continue the self investigation, the DPS was unable to conduct an objective self investigation and identify that a problem existed within the agency.</p>	H1002	<p><u>Plan of Correction Completed</u></p> <p>Winds of Agape DPS</p> <ul style="list-style-type: none"> <li>- interviewed aide on 8/20/2010 and 10/12/2010.</li> <li>- interviewed CDPAP staff on 10/12/2010</li> <li>- was refused when requested to interview client's parents</li> <li>- DPS fully understands her responsibility to self-identify areas of deficiency and to resolve problems by objectively conducting complaint investigations.</li> <li>- Full disclosure of the complaint is impossible if all parties involved refused to be interviewed by supervisors, or DPS or by independent Quality Assurance – 2 investigators: Cheryl Leatz – 8/30/2010 and Lori Marshall – 12/28/2010 – from Winds of Agape.</li> <li>- The interview with Karen Myers stated aide and interview with lawyer by Lori Marshall, found allegations the complaints are here say and no witness testimony was available to confirm allegations on 11pm-7:30am shift. The date of the original and the CDPAP staff persons were different than original allegations.</li> </ul>		<p>Completed 12/31/10</p> <p>Responsible Person: L. Torrence Admin.</p>

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H1002	<p>Continued From page 2</p> <p>Specifically:</p> <ul style="list-style-type: none"> <li>- On 09/13/10 the DPS submitted a self investigation to the DOH which failed to substantiate the complaint. Although the DPS interviewed the agency's HHA, the DPS failed to identify the correct date of the alleged incident was 08/18/10, and not 08/19/10, identify who the correct consumer directed aide was who followed the agency's HHA on 08/18/10, interview the consumer directed aide. As a result the DOH was compelled to investigate and clarify the facts of the incident for the DPS.</li> <li>- On 10/01/10 the surveyor received and reviewed a typed statement from the patient, who clarified that it was on 08/18/10 that she had a bowel movement while in the care of the agency's HHA. She stated that the wipe that the HHA used was very soiled, and so she (the patient) requested that the HHA wipe her again, and that the HHA had refused. The statement also clarified that the name of the consumer directed aide, who relieved the agency's HHA in question, was different from the name given to the DOH during the complaint intake process.</li> <li>- On 10/13/10, the surveyor interviewed the correct consumer directed aide, who stated: her shift started on 08/18/10 at 7:30 AM, which was immediately following the agency's HHA's shift; soon after she arrived, the patient communicated that she had to void; following the patient's void, the consumer directed aide cleaned the patient and noticed she had old fecal material between her buttocks; 5 wipes were required to adequately clean the remaining fecal material, it appeared that it had been there "awhile", and that it had</li> </ul>	H1002	<p><u>Plan of Correction Complete</u></p> <p>When DOH informed DPS that Brittany was staff person and the date was 8/18/2010. DPS interviewed all persons willing to confirm or not confirm evidence of occurrence. Interview of staff K. Myers done 10/12/2010.</p> <p>Interview of CDPAP staff done on 10/12/2010 – <u>Brittany interview by independent investigator completed for staff and CDPAP staff K. Myers</u> notes stated no BM occurs on new day - 8/18/2010 on 11pm-7:30am shift. Client had no BM on 8/19/2010. Day shift 8am after being put on commode at 7:45am. Insufficient evidence to state that BM occurred on 11pm-7:30am shift. <u>When Brittany transferred client from bed to commode at 7:45am there was no smell and no evidence that client had BM left from 11pm-7:30am shift.</u></p> <p>Madison County Supervisor stated K. Myers follows care plan and gives satisfactory personal care 8/5/2010.</p>	<p>Completed 12/31/2010</p> <p>Responsible Person: Lori Marshall QA Officer</p>

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H1002	<p>Continued From page 3</p> <p>been partially cleaned.</p> <p>Additionally, the consumer directed aide stated to the surveyor the patient always told her when she needed to have a bowel movement, and never has had any bowel leakage, or incontinence.</p> <p>The aide provided a written statement to the surveyor which documented the above facts.</p> <p>- On 10/19/10 the surveyor contacted the DPS and notified the DPS of the correct date of the incident (10/18/10), and the correct name of the consumer directed aide. The surveyor advised the DPS that the complaint was substantiated in that both the patient and the consumer directed aide gave the same information indicating that the agency's HHA failed to adequately cleanse the patient following a bowel movement, the bowel movement had been there for awhile, and had only been partially cleaned.</p> <p>Additionally, the surveyor advised the DPS that the consumer directed aide was amenable to being interviewed by the DPS, and directed the DPS to continue to investigate and resubmit a revised self investigation now that she was given the correct information.</p> <p>- On 10/22/10 the DPS submitted a revised self investigation and documented that although she had interviewed the consumer directed aide, who had confirmed the facts as stated to the surveyor, she (the DPS) was unable to substantiate the complaint.</p> <p>Although the DOH assisted the DPS with the self investigation by obtaining and providing the</p>	H1002	<p><u>Plan of Correction</u></p> <p>Review of notes for J.H. shows client had episodes of incontinence urine and stool and problems with urinary urgency and hesitancy. Ms. J.H.'s lawyer on 12/29/2010 stated there was no complaint stated to him by client or family regarding failure to follow care plan nor compliant of incomplete peri care after BM by K. Myers on 8/18/2010. On 10/22/2020, WOA DPS submitted a revised self-investigation. We are still unable to substantiate the allegation.</p>	<p>Completed 12/31/2010 Responsible Person: L. Torrence</p>	

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H1002	<p>Continued From page 4</p> <p>correct information to her, the DPS was still unable to objectively investigate and substantiate the complaint. Specifically:</p> <ul style="list-style-type: none"> <li>- Although the surveyor clarified the correct identity of the consumer directed aide, and the DPS interviewed her, the DPS documented she could not substantiate the complaint because the consumer directed aide originally identified was incorrect.</li> <li>- Although the DPS interviewed the correct consumer directed aide, the DPS failed to confirm with the aide that the bowel movement had been there awhile and partially cleaned, and that the patient was always aware of when she was about to have a bowel movement, and was never incontinent of stool.</li> <li>- The DPS documented she could not substantiate the complaint because the family had refused to speak to her, however, the surveyor communicated to the DPS specifically what the patient's concerns were.</li> <li>- The DPS documented she could not substantiate the complaint because the family never voiced a complaint directly to the agency. The DPS failed to identify that it is a patient right to file a complaint directly with the NY State Department of Health, and the agency was responsible for fully investigating all complaints, whether or not voiced directly to the agency.</li> <li>- The DPS stated to the surveyor on 10/19/10 that the patient was "very particular about the personal care she received", the consumer directed aide was only in her mid twenties, and the agency HHA was a more mature women.</li> </ul>	H1002	<p><u>Plan of Correction</u></p> <p>Department of Health never interviewed Winds of Agape Aide K. Myers which would have revealed that K. Myers stated client had no BM on 11pm-7:30am shift on 8/18/2010. Aide stated she always gave client complete peri care after use of commode. The parents were away at camp and the boyfriend never complained that K. Myers was disrespectful nor refused to give complete personal care to client J.H. on 8/18/2010 nor 8/19/2010. Winds of Agape DPS only discussed age of caregivers because original allegation stated \K. Myers gave report to CDPAP Emmie on 8/19/2010 – 8/20/2020 night shift. On 10/10/2010, DOH Investigator stated that Brittany was CDPAP staff but it was different aide Winds of Agape and DPS respects client's right to prefer any caregiver with no regard to staffs age.</p>	<p>Completed 12/31/2010 Responsible Person: Lori Marshall QA Officer</p>



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H1002	<p>Continued From page 5</p> <p>The DPS failed to identify the patient was vulnerable, had a right to be particular about the personal care she received, the ages of the caregivers were not relevant to the investigation, and that the HHA is obligated to implement the plan of care.</p> <p>Despite the agreement of both the patient, and the consumer directed aide, that the agency's HHA had refused to properly clean the patient following a bowel movement, the DPS failed to objectively investigate the complaint, identify that the complaint was valid, and develop an action plan to avoid a reoccurrence of a similar problem.</p>	H1002	<p><u>Plan of Correction Completed</u></p> <p>WOA had yearly satisfaction surveys about 90% of surveys have been returned (50 clients).</p> <p>There has been no patient response identifying poor physical care or failure to follow care plan. WOA will conduct yearly satisfaction surveys to identify clients who are dissatisfied with personal care given or who have failed to follow care plan. All different practices identified in yearly satisfaction survey will be identified corrective actions; in-services will be completed by staff to ensure excellent care practices and client satisfaction. This yearly satisfaction survey plus monthly spot checks, supervisory visits for all staff. Clinical skills review done each year for all CHHA's. The QA Committee will meet quarterly and review all compliments and complaints and results of yearly satisfaction survey will be reviewed staff corrective plan, suspension or termination will be discussed. Actions will be taken to ensure that deficient practices will not recur. The date correction is 12/31/2010. Responsible persons Administrator, LaVerne Torrence and QA Officer Lori Marshall will ensure all above actions be carried out. WOA will hire legal consultant for all future self-investigations and review of complaints to ensure objective, equitable self-investigations of complaints</p>		<p>Completed 12/31/2010 Responsible Person: Lori Marshall QA Officer</p>



# STATE OF NEW YORK DEPARTMENT OF HEALTH

Central NY Region

217 South Salina Street

Syracuse, New York 13202

Richard F. Daines, M.D.  
Commissioner

James W. Clyne, Jr.  
Executive Deputy Commissioner

December 10, 2010

Roderick Torrence, CEO  
Winds of Agape Home Care Agency  
1414 Grant Boulevard  
Syracuse, NY 13208

Agency: Winds Of Agape Home Care Agency  
License #: 1090L001  
Type of Survey: Complaint Investigation  
Complaint # NY00090535  
Event ID #: UEPS11  
Survey Exit Date: December 9, 2010  
**Plan of Correction Due Date: December 27, 2010**

Dear Mr. Torrence:

Enclosed is a copy of the Statement of Deficiency (SOD) report resulting from the Article 36 offsite complaint investigation conducted by staff from this office. This is being sent to you in your capacity as the Operator of this agency. You are responsible for the agency's compliance with all applicable rules and regulations. A copy of the SOD report is being forwarded to the agency's Administrator.

A detailed Plan of Correction (POC) must be completed and returned to this office by the above referenced date. The POC should be documented on the right side of the SOD report sent to the administrator and must be **signed and dated at the bottom of the first page**. A copy should be retained for the records of the agency.

Your POC must contain the following for each deficiency cited:

- What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;

- What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and
- The date for the correction and the title of the person responsible for correction of each deficiency.

This office will review your POC, if your POC is unacceptable, staff from our office will contact you to discuss the items involved.

Please contact Helene DeMartino at (315) 477-8532 with any questions.

Sincerely,

*Helene DeMartino for Lynn Shannon*

Lynn C. Shannon  
Home and Community Based Program Manager

LCS/mls

cc: Laverne Torrence, Administrator

New York State Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments  On 08/23/10 the New York State Department of Health (DOH) received a complaint (Complaint # NY 000 90535) regarding patient care being provided by the Licensed Home Care Services Agency (LHCSA).  On 08/24/10 the DOH requested the LHCSA conduct a self investigation.  Despite two submissions by the LHCSA of a self investigation, and assistance from the DOH, the LHCSA was unable to conduct a thorough and objective investigation of the complaint.  This statement of deficiencies is the result of an off site investigation conducted by the DOH due to the LHCSA's inability to conduct a self investigation, identify and correct agency problems, adequately supervise home health aides.	H 000	<u>Plan of Correction Completed</u> Winds of Agape under DPS began self-investigation of NY 00090535 on 8/20/2010 to 9/13/2010 and 10/12/2010 to present – 1/3/11 investigation was impeded by the refusal of client, family and staff to be interviewed by Winds of Agape Home Care agency. Winds of Agape Home Care Agency will begin corrective action immediately for any patients found to have affected by any deficient practice. Interviews will be conducted of client, family, staff involved in each complaint, aide involved. Corrective measures, in-services, counseling and possible suspension will occur as needed.	Completed 12/31/2010 Responsible Person: L. Torrence
H1002	766.9(a) Governing authority  Section 766.9 Governing authority.  The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall:  (a) be responsible for the management and operation of the agency;  (b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations.  This Regulation is not met as evidenced by:	H1002	<u>Plan of Correction Completed</u> The Governing Authority of Winds of Agape Home Care Agency and Quality Assurance Committee are responsible meets quarterly for management and operation of the agency and ensure compliance of all home care services in compliance with all federal, state, and local rules and regulations.	Completed 1/3/2010 Responsible Person: L. Torrence Admin.

Office of Health Systems Management / Office of Long Term Care

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *L. Torrence* TITLE \_\_\_\_\_ (X6) DATE *1/4/2011*  
STATE FORM 6899 Version NYS 11/03/2010 UEPS11 *Administrative* If continuation sheet 1 of 6

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H1002	<p>Continued From page 1</p> <p>Based on a review of the agency's self investigation of a complaint, and documentation submitted by the patient; and interviews with the the Director of Patient Services (DPS), and the patient's consumer directed aide; there is no evidence the DPS understood her responsibility to self identify, and resolve problems within the agency by objectively conducting complaint investigations</p> <p>Failure of the agency to understand their responsibility to self identify and correct problems within the agency has the potential for unmet patient's needs, and possible negative patient outcomes.</p> <p>Evidence is as follows:</p> <p>Patient #1 is a [REDACTED] with a primary diagnosis of brain injury, and a secondary diagnosis of paralysis. On 08/24/10 the NY State Department of Health sent a letter to the agency requesting the agency investigate a complaint that alleged that on 08/19/10 a Home Health Aide (HHA) employed by the agency, failed to follow the plan of care. Specifically, the patient had requested that the agency's HHA clean her more thoroughly following a bowel movement, and that the HHA had refused. Despite assistance from the DOH, the agency DPS was unable to perform an effective self investigation of the complaint. As a result the DOH was compelled to investigate and clarify the facts of the incident for the DPS. Despite this assistance from the DOH, and direction from the DOH to continue the self investigation, the DPS was unable to conduct an objective self investigation and identify that a problem existed within the agency.</p>	H1002	<p><u>Plan of Correction Completed</u></p> <p>Winds of Agape DPS</p> <ul style="list-style-type: none"> <li>- interviewed aide on 8/20/2010 and 10/12/2010.</li> <li>- interviewed CDPAP staff on 10/12/2010</li> <li>- was refused when requested to interview client's parents</li> <li>- DPS fully understands her responsibility to self-identify areas of deficiency and to resolve problems by objectively conducting complaint investigations.</li> <li>- Full disclosure of the complaint is impossible if all parties involved refused to be interviewed by supervisors, or DPS or by independent Quality Assurance – 2 investigators: Cheryl Leatz – 8/30/2010 and Lori Marshall – 12/28/2010 – from Winds of Agape.</li> <li>- The interview with Karen Myers stated aide and interview with lawyer by Lori Marshall, found allegations the complaints are here say and no witness testimony was available to confirm allegations on 11pm-7:30am shift. The date of the original and the CDPAP staff persons were different than original allegations.</li> </ul>		<p>Completed 12/31/10</p> <p>Responsible Person: L. Torrence Admin.</p>

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H1002	<p>Continued From page 2</p> <p>Specifically:</p> <ul style="list-style-type: none"> <li>- On 09/13/10 the DPS submitted a self investigation to the DOH which failed to substantiate the complaint. Although the DPS interviewed the agency's HHA, the DPS failed to identify the correct date of the alleged incident was 08/18/10, and not 08/19/10, identify who the correct consumer directed aide was who followed the agency's HHA on 08/18/10, interview the consumer directed aide. As a result the DOH was compelled to investigate and clarify the facts of the incident for the DPS.</li> <li>- On 10/01/10 the surveyor received and reviewed a typed statement from the patient, who clarified that it was on 08/18/10 that she had a bowel movement while in the care of the agency's HHA. She stated that the wipe that the HHA used was very soiled, and so she (the patient) requested that the HHA wipe her again, and that the HHA had refused. The statement also clarified that the name of the consumer directed aide, who relieved the agency's HHA in question, was different from the name given to the DOH during the complaint intake process.</li> <li>- On 10/13/10, the surveyor interviewed the correct consumer directed aide, who stated: her shift started on 08/18/10 at 7:30 AM, which was immediately following the agency's HHA's shift; soon after she arrived, the patient communicated that she had to void; following the patient's void, the consumer directed aide cleaned the patient and noticed she had old fecal material between her buttocks; 5 wipes were required to adequately clean the remaining fecal material, it appeared that it had been there "awhile", and that it had</li> </ul>	H1002	<p><u>Plan of Correction Complete</u></p> <p>When DOH informed DPS that Brittany was staff person and the date was 8/18/2010. DPS interviewed all persons willing to confirm or not confirm evidence of occurrence. Interview of staff K. Myers done 10/12/2010.</p> <p>Interview of CDPAP staff done on 10/12/2010 – Brittany interview by independent investigator completed for staff and CDPAP staff K. Myers notes stated no BM occurs on new day - 8/18/2010 on 11pm-7:30am shift. Client had no BM on 8/19/2010. Day shift 8am after being put on commode at 7:45am. Insufficient evidence to state that BM occurred on 11pm-7:30am shift. When Brittany transferred client from bed to commode at 7:45am there was no smell and no evidence that client had BM left from 11pm-7:30am shift. Madison County Supervisor stated K. Myers follows care plan and gives satisfactory personal care 8/5/2010.</p>	<p>Completed 12/31/2010 Responsible Person: Lori Marshall QA Officer</p>	

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H1002	<p>Continued From page 3</p> <p>been partially cleaned.</p> <p>Additionally, the consumer directed aide stated to the surveyor the patient always told her when she needed to have a bowel movement, and never has had any bowel leakage, or incontinence.</p> <p>The aide provided a written statement to the surveyor which documented the above facts.</p> <p>- On 10/19/10 the surveyor contacted the DPS and notified the DPS of the correct date of the incident (10/18/10), and the correct name of the consumer directed aide. The surveyor advised the DPS that the complaint was substantiated in that both the patient and the consumer directed aide gave the same information indicating that the agency's HHA failed to adequately cleanse the patient following a bowel movement, the bowel movement had been there for awhile, and had only been partially cleaned.</p> <p>Additionally, the surveyor advised the DPS that the consumer directed aide was amenable to being interviewed by the DPS, and directed the DPS to continue to investigate and resubmit a revised self investigation now that she was given the correct information.</p> <p>- On 10/22/10 the DPS submitted a revised self investigation and documented that although she had interviewed the consumer directed aide, who had confirmed the facts as stated to the surveyor, she (the DPS) was unable to substantiate the complaint.</p> <p>Although the DOH assisted the DPS with the self investigation by obtaining and providing the</p>	H1002	<p><u>Plan of Correction</u></p> <p>Review of notes for J.H. shows client had episodes of incontinence urine and stool and problems with urinary urgency and hesitancy. Ms. J.H.'s lawyer on 12/29/2010 stated there was no complaint stated to him by client or family regarding failure to follow care plan nor compliant of incomplete peri care after BM by K. Myers on 8/18/2010. On 10/22/2010, WOA DPS submitted a revised self-investigation. We are still unable to substantiate the allegation.</p>	<p>Completed 12/31/2010 Responsible Person: L. Torrence</p>

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H1002	<p>Continued From page 4</p> <p>correct information to her, the DPS was still unable to objectively investigate and substantiate the complaint. Specifically:</p> <ul style="list-style-type: none"> <li>- Although the surveyor clarified the correct identity of the consumer directed aide, and the DPS interviewed her, the DPS documented she could not substantiate the complaint because the consumer directed aide originally identified was incorrect.</li> <li>- Although the DPS interviewed the correct consumer directed aide, the DPS failed to confirm with the aide that the bowel movement had been there awhile and partially cleaned, and that the patient was always aware of when she was about to have a bowel movement, and was never incontinent of stool.</li> <li>- The DPS documented she could not substantiate the complaint because the family had refused to speak to her, however, the surveyor communicated to the DPS specifically what the patient's concerns were.</li> <li>- The DPS documented she could not substantiate the complaint because the family never voiced a complaint directly to the agency. The DPS failed to identify that it is a patient right to file a complaint directly with the NY State Department of Health, and the agency was responsible for fully investigating all complaints, whether or not voiced directly to the agency.</li> <li>- The DPS stated to the surveyor on 10/19/10 that the patient was "very particular about the personal care she received", the consumer directed aide was only in her mid twenties, and the agency HHA was a more mature women.</li> </ul>	H1002	<p><u>Plan of Correction</u></p> <p>Department of Health never interviewed Winds of Agape Aide K. Myers which would have revealed that K. Myers stated client had no BM on 11pm-7:30am shift on 8/18/2010. Aide stated she always gave client complete peri care after use of commode. The parents were away at camp and the boyfriend never complained that K. Myers was disrespectful nor refused to give complete personal care to client J.H. on 8/18/2010 nor 8/19/2010. Winds of Agape DPS only discussed age of caregivers because original allegation stated \K. Myers gave report to CDPAP Emmie on 8/19/2010 – 8/20/2020 night shift.</p> <p>On 10/10/2010, DOH Investigator stated that Brittany was CDPAP staff but it was different aide Winds of Agape and DPS respects client's right to prefer any caregiver with no regard to staffs age.</p>	<p>Completed 12/31/2010 Responsible Person: Lori Marshall QA Officer</p>



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H1002	<p>Continued From page 5</p> <p>The DPS failed to identify the patient was vulnerable, had a right to be particular about the personal care she received, the ages of the caregivers were not relevant to the investigation, and that the HHA is obligated to implement the plan of care.</p> <p>Despite the agreement of both the patient, and the consumer directed aide, that the agency's HHA had refused to properly clean the patient following a bowel movement, the DPS failed to objectively investigate the complaint, identify that the complaint was valid, and develop an action plan to avoid a reoccurrence of a similar problem.</p>	H1002	<p><u>Plan of Correction Completed</u></p> <p>WOA had yearly satisfaction surveys about 90% of surveys have been returned (50 clients).</p> <p>There has been no patient response identifying poor physical care or failure to follow care plan. WOA will conduct yearly satisfaction surveys to identify clients who are dissatisfied with personal care given or who have failed to follow care plan. All different practices identified in yearly satisfaction survey will be identified corrective actions; in-services will be completed by staff to ensure excellent care practices and client satisfaction. This yearly satisfaction survey plus monthly spot checks, supervisory visits for all staff. Clinical skills review done each year for all CHHA's. The QA Committee will meet quarterly and review all compliments and complaints and results of yearly satisfaction survey will be reviewed staff corrective plan, suspension or termination will be discussed. Actions will be taken to ensure that deficient practices will not recur. The date correction is 12/31/2010. Responsible persons Administrator, LaVerne Torrence and QA Officer Lori Marshall will ensure all above actions be carried out. WOA will hire legal consultant for all future self-investigations and review of complaints to ensure objective, equitable self-investigations of complaints</p>		<p>Completed 12/31/2010</p> <p>Responsible Person: Lori Marshall QA Officer</p>



# STATE OF NEW YORK DEPARTMENT OF HEALTH

Central New York Regional Office  
217 South Salina Street Syracuse, New York 13202

Richard F. Daines, M.D.  
Commissioner

October 29, 2010

James W. Clyne, Jr.  
Executive Deputy Commissioner

Tonya Currier, Administrator/Operator  
New Beginnings Home Care, Inc.  
12-14 East Garden Street  
Auburn, NY 13021

Agency: New Beginnings Home Care, Inc. LHCSA  
License #: 1501L001  
Type of Survey: Complaint Investigation # NY00091525  
Event ID #: LK4N11  
Survey Exit Date: 09/23/2010  
**Plan of Correction Due Date: November 12, 2010**

Dear Ms. Currier:

Enclosed is a copy of the Statement of Deficiency (SOD) report resulting from the Article 36 complaint survey of your agency by staff from this office. This is being sent to you in your capacity as the Operator of this agency. You are responsible for the agency's compliance with all applicable rules and regulations. A copy of the SOD report is being forwarded to the agency's Administrator.

Due to the seriousness of the deficiencies, this office is planning to recommend to the Bureau of Home Health Care Services the implementation of an enforcement action/imposition of a fine.

A detailed Plan of Correction (POC) must be completed and returned to this office by the above referenced date. The POC should be documented on the right side of the SOD report sent to the administrator and must be **signed and dated on the bottom of the first page**. A copy should be retained for the records of the agency.

Your POC must contain the following for each deficiency cited:

- What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and
- The date for the correction and the title of the person responsible for correction of each deficiency.

This office will review your POC, if your POC is unacceptable, staff from our office will contact you to discuss the items involved.

Sincerely,



Lynn C. Shannon  
Home and Community Based Program Manager

LCS/mls

New York State Department of Health

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H 000	Initial Comments  An on-site complaint investigation for complaint #NY00091525 was conducted at this licensed home care agency on 9/22/10 and 9/23/10. The investigation consisted of a review of one patient record, the agency complaint log, and policies and procedures. Interviews were conducted with the RN, President, Service Coordinator for the Nursing Home Transition and Diversion (NHTD) Waiver, and the Human Resources Supervisor.  The complaint was substantiated as a result of this investigation and the following deficiencies were identified.	H 000			
H 408	766.3(d) Plan of care  766.3 Plan of care.  The governing authority or operator shall ensure that:  ..... (d) the plan of care is reviewed and revised as frequently as necessary to reflect the changing care needs of the patient, but no less frequently than every six months;  (1) each review shall be documented in the clinical record; and  (2) agency professional personnel shall promptly alert the patient's authorized practitioner and other affected care providers to any significant changes in the patient's condition that indicate a need to alter the plan of care. This Regulation is not met as evidenced by: Based on review of one patient record and interview with the agency RN, the RN failed to review and revise the nursing assessment and plan of care at least every six months, and failed	H 408			

Office of Health Systems Management / Office of Long Term Care

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

New York State Department of Health

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H 408	<p>Continued From page 1</p> <p>to notify the physician of changes in the patient's condition.</p> <p>Failure to ensure that the plan of care is reviewed and revised at least every six months, and failure to promptly alert the patient's physician of any significant changes in patient condition may lead to unmet patient needs and/or negative outcomes. A negative outcome occurred with this patient.</p> <p>This [REDACTED] patient was admitted to the agency on 12/30/08, and the agency was providing Home and Community Support Services 24 hours per day, 7 days per week through the Nursing Home Transition and Diversion Medicaid Waiver. The patient record lacked evidence of nursing assessments performed every 6 months since the start of care date. The only nursing assessment found in the record was dated 7/14/10, conducted after the patient returned home from a 5 day hospitalization.</p> <p>Based on review of documentation in the patient record, the patient was hospitalized 7/9/10-7/14/10 for diagnoses of E-Coli, urinary tract infection and dehydration. The hospital discharge instructions dated 7/14/10 included the following instructions: offer the patient fluids every two hours when awake, antibiotics prescribed four times a day, and eat yogurt while on antibiotics.</p> <p>There is no evidence that the RN:</p> <ul style="list-style-type: none"> <li>-Notified the patient's physician of the patient's hospitalization and subsequent change in condition, such as the need for continuous monitoring to ensure adequate intake of fluids.</li> <li>-Consulted with the physician regarding any</li> </ul>	H 408			

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H 408	Continued From page 2  necessary changes to the patient's plan of care, such as monitoring the patient's fluid input and urinary output. -Updated the patient's plan of care to include these discharge instructions and change in status.  Additionally, when the RN conducted the assessment on 7/14/10, she identified that a urine collection device should be obtained for the staff to measure the patient's urinary output. No evidence was found in the record that the physician was consulted regarding this, that a device was ever obtained, or that this task was added to the patient's plan of care. A plan to monitor urinary output was not included on the hospital discharge instructions.  The patient was admitted to the hospital again on 9/1/10 for dehydration and renal failure and has not received home care services from this agency since that date. Based on the surveyor's interview with the agency RN on 9/23/10, the RN stated that there has been no communication to the patient's physician since the patient was hospitalized on 9/1/10. Additionally, there was no evidence in the patient record that the RN or other agency designee informed the physician and/or consulted with him regarding this change in patient status.  The surveyor reviewed the above information with the RN and President on 9/22/10 and 9/23/10. No further evidence was provided.	H 408			
H 618	766.5(b)(3) Clinical supervision  766.5 Clinical supervision. The governing authority shall ensure for all health care services that:	H 618			

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H 618	<p>Continued From page 3</p> <p>.....</p> <p>(b) all staff delivering care in patient homes are adequately supervised. The department shall consider the following factors as evidence of adequate supervision:</p> <p>.....</p> <p>(3) clinical records are kept complete and changes in patient condition, adverse reactions, and problems with informal supports or home environment are charted promptly and reported to supervisory staff.</p> <p>This Regulation is not met as evidenced by: Based on review of the patient record, the patient's case communication log book, daily shift report, agency on-call log, and interview with the agency RN, there is no evidence that any changes in patient condition were reported to the supervising RN.</p> <p>Failure to provide adequate supervision of staff delivering care in patient homes may lead to unmet patient needs and/or negative outcomes. This patient suffered a negative outcome.</p> <p>Specifically, the aides working with this patient documented completion of their tasks for each shift on an "aide flow sheet" and submitted those weekly to the agency for review. The aides also kept a case communication notebook in the patient's home, where a more detailed description of the patient's condition and the events that transpired on each shift were documented. This notebook was kept in the patient's home and was not available to the RN to review.</p> <p>Agency staff picked up the communication book from the patient's home after the patient was hospitalized on 9/1/10. The case communication book showed evidence of documentation of changes in the patient's condition on a number of</p>	H 618		

New York State Department of Health

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NAME OF PROVIDER OR SUPPLIER  <b>NEW BEGINNINGS HOME CARE INC LHCSA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>12-14 EAST GARDEN STREET AUBURN, NY 13021</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
H 618	<p>Continued From page 4</p> <p>days that were not communicated to the RN. Examples are as follows:</p> <p>8/24/10 "Patient also has rash in inner buttocks, make sure we are all washing, drying, etc. accordingly. Apply Vaseline/ A-D ointment."</p> <p>There is no evidence that the RN was informed of this change in patient condition, or that the RN gave the personal care aide direction in caring for the rash.</p> <p>Sunday 8/29/10-8/30/10 [9PM-9AM] "HCSS arrived patient was slumped over in her chair, just really didn't seem like herself. She seemed very tired and out of it. HCSS (PCA) started looking her over and noticed that the left side of her jaw was slightly swollen. HCSS pressed and she made a face so I called on-call ASAP to report that she may possibly have an abscess. Spoke to (Human Resources supervisor who was covering the on-call), she said that she will have Service Coordinator come over Monday morning to check her out. HCSS gave meds and cleaned patient up and then put her to bed. Checked every two hours and patient was fine."</p> <p>There is no evidence that the on-call supervisor ever notified the RN to report that the patient had swelling to the left side of her jaw, and the overall change in physical condition. Instead, the on-call supervisor made a determination that the patient's needs were not urgent and that she could be assisted on the following day. There was no evidence that the RN ever assessed the patient the following day.</p> <p>8/30/10-8/31/10 [8PM-9AM] "Patient very weak, shaky, not talking or responding or cooperating at all this AM!"</p>	H 618			



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H 618	<p>Continued From page 5</p> <p>There is no evidence that this was reported to the supervising RN.</p> <p>8/31/10 [9AM-9PM] "Patient is very tired, not really herself, is not really able to stand up or do much of anything."</p> <p>There is no evidence that this was reported to the supervising RN.</p> <p>8/31/10-9/1/10 [8PM-9AM] "Patient unable to sleep throughout the night due to extreme pain (right side jaw). Patient up at 1AM, 3AM, and 5AM. Up at 8:25 AM, unable to have full shower, oral/mouth care."</p> <p>"Patient is extremely tired/sluggish/sitting in wheelchair upon HCSS 9AM shift. Patient was unable to eat a meal/ uninterested to watching TV (very quiet/sleepy)."</p> <p>There is no evidence that this was reported to the supervising RN.</p> <p>On Monday 9/1/10 at 10 AM, the aide reported to the patient's Nursing Home Transition and Diversion Waiver Service Coordinator (also of this agency) that the patient was weak, in some pain, and had a hard time swallowing her medications, still assuming the patient had an abscessed tooth. The Service Coordinator scheduled an emergency dental appointment for 11:50 AM that day, but the patient never made it to the appointment, as the Medicaid transportation failed to show up. The patient and the PCA instead went to the hospital emergency room later that afternoon, but because of the long wait at the ER, decided at around 5 PM to go to an urgent care. Upon arrival at urgent care, the patient was non-responsive and unable to get out</p>	H 618			

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H 618	<p>Continued From page 6</p> <p>of the vehicle, and the nurse at urgent care called for an ambulance to transfer the patient back to the hospital. By 8:17 PM the patient had been admitted to the hospital with possible renal failure.</p> <p>Evidence was found in the on-call log that the aide who had accompanied the patient to the hospital had contacted the on-call supervisor with updates regarding the patient's condition at 5:22 PM, 7:30 PM, and 8:22 PM. No evidence was found that the on-call supervisor ever reported these updates about the patient's condition to the RN.</p> <p>Additionally, forms titled "Daily shift report" were kept in a binder in the patient's home for the aides to record the following information regarding the patient daily: Fluids provided, meals/snacks, bathing, mood, sleep, urine output, bowels, and pain.</p> <p>Based on review of documentation of daily shift reports dated 8/18/10-9/1/10, the patient did not have a bowel movement on 8/19/10, 8/21/10, 8/26/10, 8/28/10, 8/30/10, and 8/31/10. Also, the patient did not urinate on 8/31/10 from early morning until 9/1/10 at 8:25 AM. It was also noted that the patient was in "a lot" of pain the entire day of 9/1/10.</p> <p>Additionally, the aides documented the amount of fluids supplied to the patient daily, and the total was never more than 1200 cc's in a day between 8/18/10 and 9/1/10. There was no evidence that fluids were offered every two hours (as per previous hospital discharge orders dated 7/14/10).</p> <p>None of the aforementioned information</p>	H 618			

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H 618	Continued From page 7  regarding the patient's condition was reported to the supervising RN. The patient was taken to the hospital emergency department on 9/1/10 and was subsequently admitted to the hospital. Based on review of the hospital's discharge summary dated 9/22/10, the following were the patient's final diagnoses: -Acute renal failure secondary to dehydration and hypercalcemia -Hypercalcemia secondary to dehydration and bone demineralization from immobilization -Dental abscess left lower jaw at tooth #19 -Pressure sores on the buttock which have resolved  Prior to discharge from the hospital, medical professionals had determined that the patient was unable to return home safely with 24-hour home care services, and was since admitted to a nursing home.  The surveyor reviewed this information with the RN on 9/23/10. No further evidence was provided.	H 618			
H 624	766.5(d) Clinical supervision  766.5 Clinical supervision. The governing authority shall ensure for all health care services that: ..... (d) in-home supervision by professional staff of home health aides and personal care aides occurs:  (1) to demonstrate to and instruct the aide in the treatments or services to be provided with successful redemonstration by the aide during the initial service visit or where there is a change in personnel providing care, if the aide does not	H 624			

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H 624	<p>Continued From page 8</p> <p>have documented training and experience in performing the tasks prescribed in the plan of care;</p> <p>(2) where any of the conditions set forth in paragraph (3) of subdivision (b) of this section occur, to evaluate the condition and initiate any revision in the plan of care which may be needed; and</p> <p>(3) to instruct the aide as to the observations and written reports to be made to the supervising nurse or therapist.</p> <p>This Regulation is not met as evidenced by: Based on review of one patient record, 5 personnel records of para-professional staff, the agency policy for "Staff Supervision" dated July 2010, and interview with the agency RN, there is no evidence that the supervising RN conducted orientation to the case or in-home supervisory visits of any personal care aides assigned to work with this patient.</p> <p>Failure to ensure that in-home supervision of home health aides or personal care aides is conducted may lead to unmet patient needs and/or negative outcomes. This patient suffered a negative outcome as a result of lack of supervision, whereas the patient became ill and dehydrated, went into renal failure, and required hospitalization and nursing home placement.</p> <p>Specifically, the patient record and five personnel records of the personal care aides (PCAs) working with this patient lacked any evidence of supervisory reports of the PCAs. The agency staff supervision policy states that the RN is to evaluate a Home Health Aide at least every three months. The surveyor interviewed the agency RN on 09/22/10. The RN stated that she and the</p>	H 624			

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H 624	<p>Continued From page 9</p> <p>agency president discovered that the RN Supervisor who was responsible for conducting supervision of the HHAs and PCAs had failed to do so. The agency terminated this RN on 09/09/10. The agency was unable to locate any evidence of documented supervisory visits conducted while this RN was employed at the agency from February 2010 through 09/09/10.</p> <p>In addition, no documentation was found of supervisory visits conducted to demonstrate and/or instruct the aides in treatments or services to be provided as an orientation to the patient and plan of care. The agency's "Staff Supervision" policy dated July 2010 states that "Supervision will take place whenever there is new staff being introduced to a case or at an initial service visit."</p> <p>The surveyor reviewed this information with the President and agency RN on 9/23/10. No further evidence was provided.</p>	H 624		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0180L001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/05/2007</b>
NAME OF PROVIDER OR SUPPLIER <b>HOME CARE OF CORTLAND COUNTY, INC.</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 PORT WATSON STREET CORTLAND, NY 13045</b>		
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H 000	Initial Comments  This Statement of Deficiencies report is the result of an Article 36 complaint investigation [#07-06-30012]. The survey consisted of a review of 1 patient record; 1 personnel record; complaint and incident logs; and interviews with a patient and the agency's Executive Director.	H 000		
H 622	766.5(c) Clinical supervision  766.5 Clinical supervision. The governing authority shall ensure for all health care services that:  ..... (c) home health aides or personal care aides are supervised, as appropriate, by a registered professional nurse or licensed practical nurse, or a therapist if the aide carries out simple procedures as an extension of physical therapy, occupational therapy or speech/language pathology. This RULE: is not met as evidenced by: Base on a review of 1 patient record [patient #6]; 1 Home Health Aide [HHA #1] personnel record; the agency complaint and incident logs; and interviews with patient #6, and the agency's Executive Director [ED], evidence is lacking that the agency provided adequate in home supervision of HHA #1 from 8/21/06 to 6/12/07 to assess the HHA's performance and to ensure patient safety.  Specifically:  From 8/21/06 to 6/12/07 the surveyors identified that the agency received a total of 6 complaints that HHA #1 had stolen money from patients and 2 reports from the NYS Police that HHA #1 was possibly involved with manufacture of drugs.	H 622	H622 Corrective action Aug. 27, 2007  <u>Clinical supervision will be evidenced by:</u> 1. RN and or LPN documentation of aide orientation and supervisory visits. 2. RN and or LPN documentation of client communication related to satisfaction or dissatisfaction with agency services. 3. <u>Documentation</u> of complaints by RN supervisors, Home Care LPN aide supervisor, or Executive Director will include; Date of complaint, name of client, name of person making the complaint, nature of the complaint or client statement, Home Care for Cortland County Staff statement. <u>Investigation</u> will be completed by RN supervisor, Home Care LPN aide supervisor, or Executive Director; The Executive Director will notify the appropriate law enforcement personnel as warranted by the situation ( theft, assault, abuse) ; <u>Resolution</u> will be evidenced by a copy of the written or verbal communication to the client, a copy of the staff disciplinary notice, educational program title and schedule, date that the Quality Assurance Committee and the Board of Directors received a report the complaint. This is the responsibility of the Executive Director at Home Care for Cortland Co. 4. When disciplinary intervention is necessary the following will be documented on the agency warning form; Type of warning, frequency and type of employee monitoring, duration of warning. The Executive Director will share the result of monitoring with the employee at the end of the warning period.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

XZ1211

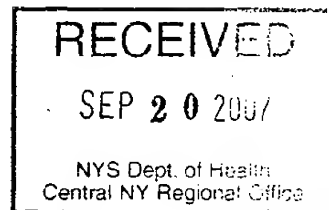
If continuation sheet 1 of 9



# Home Care for Cortland County, Inc.

Sarah  
LC's  
9/21/07

September 19, 2007

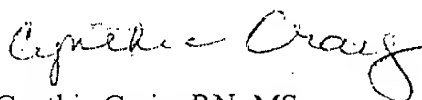


Lynn Shannon  
Home and Community Based Program Manager  
NYS Department of Health  
Central NY Regional Office  
217 South Salina Street  
Syracuse, NY 13202

Dear Lynn Shannon:

Enclosed are the deficiency report and our Plan of Correction documentation. If you have any questions, please contact our office.

Sincerely,

  
Cynthia Craig, RN, MS  
Executive Director

CC/slg  
Enclosure

New York State Department of Health

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H 622	<p>Continued From Page 1</p> <p>On 01/26/07 HHA #1 was given her employee performance evaluation for January 2006 - January 2007. It was noted on this evaluation that HHA #1 would be on 3 month probation due to failure to adhere to her schedule plus complaints of theft. The evaluation did not specify what the probation would be.</p> <p>There is no evidence that the agency increased supervision of HHA #1 during the probation period or after any patient complaints of theft by HHA #1. There is also no evidence of a review of HHA #1's performance following the 3 month probationary period.</p> <p>Failure to properly supervise Home Health Aides may lead to unmet patient needs and possible negative patient outcomes.</p> <p>A written warning form found in HHA #1's personnel file stated that the agency was notified by a patient that HHA #1 had called the patient on 05/31/07 to state she would be at work on 6/1/07. The report states the agency called HHA #1 on 06/1/07 and the aide reported she had been arrested on criminal charges related to purchase of a large amount of Sudafed and Claritin with the intent to manufacture methamphetamine.</p> <p>-- No further evidence was found that the agency conducted an investigation into this allegation or developed a resolution for this allegation.</p> <p>--It was only after the agency received this information that the agency suspended HHA#1 on 06/01/07.</p> <p>--HHA#1 was not terminated until 06/13/07</p>	H 622	<p>Changes in the Discipline Policy and the Grievance and Complaint Policy and format for recording complaints will be presented for Quality Assurance Committee review on August 28, 2007 and Board of Directors approval on September 18, 2007</p>		



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H 622	Continued From Page 2  after the agency received the sixth complaint of theft.  --During an interview with the Executive Director on 07/05/07 the ED was asked why HHA #1 was not terminated before 6/13/07. The ED stated there was not enough equivocal evidence against the HHA and "because the HHA was a good aide".	H 622			
H1020	766.9(j) Governing authority  Section 766.9 Governing authority.  The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall:  ..... (j) ensure the development and implementation of a patient complaint procedure to include:  (1) documentation of receipt, investigation and resolution of any complaint, including the maintenance of a complaint log indicating the dates of receipt and resolution of all complaints received by the agency;  (2) review of each complaint with a written response to all written complaints and to oral complaints, if requested by the individuals making the oral complaint:  (i) explaining the complaint investigation findings and the decisions rendered to date by the agency within 15 days of receipt of such complaint; and  (ii) advising the complainant of the right to appeal the outcome of the agency's complaint investigation and the appeal procedure to be	H1020	<p>H1020</p> <p><u>The Board of Directors will demonstrate adequate development and implementation of a Grievance and Complaint Procedure for Home Care for Cortland County by;</u></p> <p>Home Care for Cortland County will maintain an up to date complaint investigation log, RN supervisors, Home Care LPN aide supervisors, or Executive Director will be responsible for initial documentation of the complaint. Each complaint will be filed in the log the day it is received. The log will be kept in the Executive Director's office.</p> <p>Investigation will be completed by RN supervisor, Home Care LPN aide supervisor, or Executive Director</p> <p>Elements of any complaint investigation will include;</p> <ol style="list-style-type: none"> <li>1. Date of complaint</li> <li>2. Who filed the complaint</li> <li>3. Who recorded the complaint</li> <li>4. Nature of the complaint</li> <li>5. Client or client representative statement</li> <li>6. Agency staff statement</li> <li>7. Resolution will include</li> </ol>		

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H1020	<p>Continued From Page 3</p> <p>followed;</p> <p>(3) an appeals process with review by a member or committee of the governing authority within 30 days of receipt of the appeal; and</p> <p>(4) notification to the patient or his or her designee that if the patient is not satisfied by the agency's response, the patient may complain to the Department of Health's Office of Health Systems Management.</p> <p>This RULE: is not met as evidenced by:</p> <p>Based on a review of the agency's complaint log, the personnel file of HHA #1, a handwritten list of allegations found in HHA#1's record; the clinical record for patient #6 identified in one agency complaint, and interviews with patient #6 and the agency Executive Director, the surveyors identified that the agency received a total of 6 complaints of theft involving HHA #1 between 8/21/06 to 6/12/07.</p> <p>Evidence is lacking that the agency has ensured that the following requirements are met:</p> <ul style="list-style-type: none"> <li>-Maintenance of a complaint log</li> <li>-Documentation of a comprehensive investigation of every complaint.</li> <li>-Development of a resolution for each complaint.</li> </ul> <p>Specifically:</p> <p>Complaint #1. A grievance/complaint form found in the complaint log stated that on 8/21/06 the agency received a call from patient #1 complaining that \$28.00 was missing from patient's home. The complaint stated that HHA #1 had requested to borrow money from the client and the client had refused. The patient requested that HHA #1 not return.</p>	H1020	<ul style="list-style-type: none"> <li>• Action to correct staff behavior must include type and duration of aide supervision to ensure that correction occurs, and follow-up meeting with aide to indicate satisfactory resolution of problem behavior. RN supervisors, Home Care LPN aide supervisors, or Executive Director will be responsible for the supervision. Supervision methods may include weekly home visits and aide demonstrations until performance is satisfactory, random daily telephone calls to monitor schedule adherence, suspension during investigation for allegations of theft, abuse, assault.</li> <li>• Communication either verbal account or written account to the complainant of resolution of complaint.</li> <li>• The Executive Director will report each complaint investigated and its resolution to the Quality Assurance Committee and the Board of Directors for their consideration and action.</li> <li>• The Executive Director must sign off on all complaint investigations and resolution.</li> </ul> <p>Changes in the Grievance and Complaint Policy and format for recording complaints will be presented for Quality Assurance Committee review on August 28, 2007 and Board of Directors approval on September 18, 2007</p>	

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H1020	<p>Continued From Page 4</p> <p>Complaint #2. A grievance/complaint form found in the complaint log stated that on 10/11/06 the daughter of patient #2 called with a complaint that \$100.00 was missing from the patient's purse. HHA #1 identified in this complaint had been assigned to this patient during this time.</p> <p>Complaint #3. A grievance/complaint form found in the complaint log stated that on 03/15/07 the agency received a complaint from the Elderly Inhome Services Expansion Program [EISEP] stating that HHA #1 failed to bring back the correct change to a patient #3.</p> <p>Complaint #4. In HHA #1's personnel file a hand written list on the agency's letter head was found. This list contained allegations of theft against HHA #1. This list includes a theft from patient #4 of the amount of \$40.00 during 3/07. This complaint was not included in the complaint log.</p> <p>Complaint #5. On the same list as in complaint #4 in HHA #1 personnel file another report of a theft by patient #5 was found. No information on what patient #5 reported missing was found. The report stated HHA #1 denied this complaint. This complaint was not included in the complaint log.</p> <p>Complaint #6. A grievance/complaint form found in the complaint log stated that on 06/12/07 the agency received a complaint from a Meals On Wheels [MOW] representative. This complaint stated that patient #6 had complained to MOW that her ATM statement showed withdrawals and unsuccessful attempts of withdrawals of money from the patient's account on 05/21-22/07. Dates of withdrawals match dates and times that HHA #1 was assigned at</p>	H1020		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0180L001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/05/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME CARE OF CORTLAND COUNTY, INC.</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 PORT WATSON STREET CORTLAND, NY 13045</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
H1020	<p>Continued From Page 5</p> <p>patient #6's home.</p> <p>The agency failed to properly document, conduct adequate investigations, and ensure resolution of the above complaints.</p> <p>Specifically:</p> <p>Complaint #1. This grievance/complaint form stated that the agency interviewed by telephone HHA #1 regarding the theft of \$28.00. Patient #1 had identified HHA #1 as the only other person in the home. The aide denied taking the money.</p> <p>--The report states that the Executive Director [ED] informed HHA #1 that future allegations may be cause for termination.</p> <p>--No further evidence was found that the agency conducted an investigation into this complaint, provided increased supervision, or documented a resolution of this complaint.</p> <p>Complaint #2. This grievance/complaint form stated that HHA #1 was brought into the agency office for an interview regarding the complaint of the theft of \$100.00 made by patient #2's daughter. The form stated that HHA #1 was advised that patient #2's family was to initiate a legal investigation.</p> <p>-- The report stated that HHA #1 assignments were to be limited to alert, oriented patients with multiple family present.</p> <p>--No further evidence was found that the agency conducted an investigation into this complaint, provided increased supervision, or documented a resolution of this complaint.</p> <p>Complaint #3. This grievance/complaint form stated that patient #3 complained that HHA #1 did not return the correct change. Per the grievance/complaint form the Executive Director placed a call to HHA #1 to bring the correct change to the agency office. The agency would</p>	H1020			

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0180L001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/05/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME CARE OF CORTLAND COUNTY, INC.</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 PORT WATSON STREET CORTLAND, NY 13045</b>		
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H1020	<p>Continued From Page 6</p> <p>then return the change to the patient.</p> <p>-- No further evidence was found that the agency conducted an investigation into this complaint to identify repeated complaints of theft against HHA #1, provide increased supervision, or document a resolution of this complaint.</p> <p>Complaint #4. In HHA #1's personnel file a hand written list on the agency's letter head was found regarding a complaint of a theft. A note on this list states HHA #1 denied this allegation. This list was not dated. The list did not contain a signature of the person responsible for writing this list.</p> <p>-- No further evidence was found that the agency conducted an investigation into this complaint, provided increased supervision of HHA #1, or developed a resolution of this complaint.</p> <p>Complaint #5. On the same list noted in complaint #4 a report of another allegation of theft regarding HHA #1 was found. The list stated that HHA #1 denied this allegation.</p> <p>-- No further evidence was found that the agency conducted an investigation into this complaint, provided increase supervision of HHA #1 or developed a resolution of this complaint.</p> <p>Complaint #6. This grievance/complaint form stated that patient #6 complained of the theft of money by HHA #1 using the patient's ATM card. A copy of a letter dated 6/13/2007 addressed to HHA #1, written by the ED, was found in HHA #1 personnel file. This letter informed HHA #1 of her termination. This copy was on plain paper, not agency letterhead, and was not signed.</p> <p>--The HHA was terminated from the agency on 06/13/07.</p> <p>-- No further evidence was found that the agency conducted an investigation into this</p>	H1020			

New York State Department of Health

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NAME OF PROVIDER OR SUPPLIER  <b>HOME CARE OF CORTLAND COUNTY, INC.</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 PORT WATSON STREET CORTLAND, NY 13045</b>		
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H1020	Continued From Page 7  complaint or developed a resolution of this complaint. -- During a home interview with patient #6 the patient stated that the police have a surveillance camera video of the HHA using the patient's ATM card. The patient also stated the agency had not contacted her regarding this complaint.  No further information was provided by the ED of comprehensive investigations by the agency into the patient's complaints to check the allegations of theft for more evidence.  The agency failed to properly document, investigate, and resolve the above complaints, all involving HHA#1.  Failure to maintain complete documentation of all complaints, properly investigate, and resolve each complaint, led to negative patient outcomes.	H1020		
H1036	766.9(l) Governing authority  Section 766.9 Governing authority.  The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall:  ..... (l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided. The committee shall meet at least four times a year to:  (1) review policies pertaining to the delivery of	H1036	H1036 <u>Evidence that the Quality Assurance Committee hears all complaints will be demonstrated as the Executive Director reports all complaints to the Quality Assurance Committee at each quarterly meeting.</u> Each complaint will be identified by number beginning with 1 in January 2008 and each year thereafter. From Aug. 27, 2007 complaints will be identified by date. The complaints will be filed in the complaint log the day they are received. Elements of the complaint investigation will include 1. Date of complaint 2. Who filed the complaint 3. Who recorded the complaint 4. Nature of the complaint 5. Client or client representative statement 6. Agency staff statement 7. Investigation 8. Resolution will include • Action to correct staff behavior must include type and duration of action, methods of aide supervision to ensure that correction occurs, follow-up meeting with aide to indicate satisfactory resolution of problem behavior. • Communication either verbal account or written account to complainant of resolution of complaint. • A notation on the complaint form that investigation by RN supervisors, Home Care LPN aide supervisors, or Executive Director and complaint resolution has been forwarded to the Quality Assurance Committee and the Board of Directors for their consideration and action. (cont. next page)	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0180L001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/05/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME CARE OF CORTLAND COUNTY, INC.</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 PORT WATSON STREET CORTLAND, NY 13045</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H1036	<p>Continued From Page 8</p> <p>the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption;</p> <p>(2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes:</p> <p>(i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and</p> <p>(ii) all cases with identified patient complaints as specified in subdivision (j) of this section;</p> <p>(3) prepare and submit a written summary of review findings to the governing authority for necessary action; and</p> <p>(4) assist the agency in maintaining liaison with other health care providers in the community. This RULE: is not met as evidenced by:</p> <p>Based on a review of the patient's record; HHA #1 personnel file; the agency complaint and incident logs; evidence is lacking that the Quality Assurance Committee was informed of the pattern of complaints and allegations regarding HHA #1.</p> <p>Failure of the Quality Assurance Committee[QAC] to identify a pattern in patient complaints regarding a specific HHA, and to prepare and submit a written summary of these complaints to the governing authority for necessary action, led to negative patient outcomes.</p>	H1036	<p>H1036 cont.</p> <p>The Quality Assurance Committee will analyze each complaint on a case by case basis. Based on this analysis, they may recommend educational programs to correct problem behavior, further disciplinary action, and continued employment or not. This information will be reported to the Board of Directors at the next meeting by the Executive Director.</p> <p>The Executive Director will present changes in the Grievance and Complaint Policy and format for recording complaints will be presented for Quality Assurance Committee review on August 28, and Board of Directors approval on September 18, 2007</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVE  
OMB NO. 0938-0399

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/05/2007
NAME OF PROVIDER OR SUPPLIER  ST ELIZABETH CERTIFIED HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 14 FOERY DRIVE UTICA, NY 13501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 000	INITIAL COMMENTS	G 000			
G 101	<p>This statement of deficiencies is the result of complaint investigation #NY00045697. During the complaint investigation the surveyor reviewed the clinical record for patient #1, conducted an observational home visit and interviewed the Administrator, the Adult Protective Services case worker and agency staff.</p> <p>484.10 PATIENT RIGHTS</p> <p>The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights.</p> <p>This STANDARD is not met as evidenced by: Based on a review of the clinical record for patient #1 and interviews with the agency Administrator, Adult Protective Services (APS) case worker, the skilled nurse and the home health aide, the agency failed to treat patient #1 with respect and dignity.</p> <p>An on site investigation was conducted on 09/05/07. During the clinical record review, the following issues were identified which show the agency's failure to ensure that the patient/family is treated with respect and dignity.</p> <p>Patient #1 is a [REDACTED] who was admitted to the agency on 07/23/06 with a primary diagnosis of an upper gastrointestinal bleed and secondary diagnoses of cerebral vascular accident, hypothyroidism, dementia and replacement of the percutaneous endoscopic gastrostomy (PEG) tube. As noted in the 05/18/07 comprehensive skilled nursing re-assessment, the patient is dependent in all areas of activities of daily living</p>	<p>G101</p> <ul style="list-style-type: none"> <li>The Administrator has resigned from her position and an interim management plan has been developed and will be communicated to the NY State Department of Health within 10 days of the departure of the Administrator. 10/09/07</li> <li>The Acting Interim Administrator/Agency Director will retain responsibility for ensuring that the rights of all patients are protected and promoted. Ongoing</li> <li>The following in-services are scheduled <ul style="list-style-type: none"> <li>A presentation for the Home Health Aides entitled "Patient Abuse: Role of the Para Professional" was presented by Clinical Nurse Consultant on September 25, 2007. Evaluation Tests were completed. 9/25/07</li> <li>By October 30, 2007 a representative from the Elder Abuse Community of Oneida County will provide a presentation on recognizing and reporting elder abuse, and the role of Elder Abuse Community of Oneida County 10/30/07</li> <li>By October 30, 2007 the Risk Manager from St Elizabeth Medical Center and member the Medical Center Ethics Committee will provide a presentation for the agency staff on complaint processing, complaint resolution and the role of the Ethics Committee in identifying appropriate actions when staff encounter questionable patient 10/30/07</li> </ul> </li> </ul>			

Acceptable 10/19/07 Paula Williams RN

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Ante M. [Signature]*

*President/CEO*

*10/4/07*

Efficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/05/2007
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NAME OF PROVIDER OR SUPPLIER

ST ELIZABETH CERTIFIED HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

14 FOERY DRIVE  
UTICA, NY 13501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES: (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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G 101

Continued From page 1

and is described as bedfast. The patient's daughter is identified as the caregiver, although the patient's record states that she is physically disabled. The patient's plan of care /physician's orders dated 05/19/07 to 07/17/07, states that the patient receives skilled nursing services 1 time a week and home health aide service 7 days a week.

On 07/09/07, the New York State Department of Health received a complaint alleging the agency has failed to provide home health aide service according to the physician's orders for patient #1. The complainant states that the physician ordered 3 hours a day 4 days a week and 2 hours a day 3 days a week.

In an interview with the Administrator on 07/13/07, the surveyor asked the Administrator how many hours of home health aide are being provided and what are the patient's needs. The Administrator stated that they [home health aides] were going 2 to 3 hours a day for personal care, bath, and emptying the foley catheter.

During an onsite investigation conducted on 09/05/07, the surveyor reviewed the patient's record and found that the plan of care dated 05/19/07 to 07/17/07 included aide service 7 days a week, however, the number of hours of aide is to provide each visit is lacking. A review of the aide task sheets form 05/19/07 to 07/17/07, identified that the agency provided a range in hours per visit from 1 hour per visit to 3 hours per visit. Of the 60 possible visits, the patient only received 10 visits in which care was provided for 3 hours per visit. The aide assignment sheet did not delineate any additional tasks that should be completed while the aide was there for 3 hours.

G 101

situations with unmet patient needs.

- o A Self Paced Work Book for the Professional Staff Elder Abuse and Neglect will be distributed to all clinical staff on October 3, 2007 with completed competency test due October 13, 2007.

10/13/07

- The summary reports from the Press Ganey Satisfaction Questionnaires currently being sent to a random set of the agency's patients will be closely monitored. Evaluation of the following indicators from the most recent report (Jan 07 - June 07) was completed on Sept. 26, 07 by an external clinical consultant. This data was pulled into a QA spreadsheet for future tracking purposes. The agency QA RN will evaluate the next available report in 1<sup>st</sup> Quarter 2008 to assess need for further action plans and will forward to the QA committee for consideration.

Ongoing

- o The following are the Press Ganey Indicators that pertain to patient rights that will have focus tracking until they reach benchmark of 90%.
  - Aides concern for your privacy
  - Aides concern for your comfort while treating or caring for you
  - Amount of attention the aides paid to your own ideas about your care
  - Aides' concern to

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  ST ELIZABETH CERTIFIED HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 14 FOERY DRIVE UTICA, NY 13501	

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G 101	Continued From page 2  During the interview with the Administrator on 07/13/07, the Administrator voiced her concerns regarding the patient's safety and the daughter's inability to provide care for this patient. The surveyor asked the Administrator if she had made a referral to Adult Protective Services (APS) to evaluate the patient's safety needs. The administrator stated that she made a referral to APS and that APS had no findings. The administrator then informed the surveyor that she "told the daughter in past, that the agency does not provide babysitting service."  In reviewing the Administrator's documentation of the 07/13/07 interview with the surveyor, the surveyor noted that the administrator documented that she "told the daughter in the past, we are not a babysitting service."  The Administrator also documented that she immediately placed a call to the patient's daughter to "discuss just what does she want?" The daughter was not home at the time and the Administrator called her back on 07/16/07.  The Administrator documented in a progress note dated 07/16/07, that she called the patient's daughter and asked her what she wanted. The Administrator documented that patient's daughter wants "28 hours for her mother, she's entitled to this, I [the Administrator] said not for babysitting". The Administrator continued to inform the daughter that the agency does not provide care 24 hours a day and that is what her mother needs.  In an interview with Adult Protective Service on 08/21/07, the surveyor was informed that the	G 101	<p>contact you if he or she could not make it, or would be coming late</p> <ul style="list-style-type: none"> <li>▪ Aides' sensitivity to the personal difficulties and inconvenience caused by your health problem</li> <li>○ Clinical professional staff <ul style="list-style-type: none"> <li>▪ Nurses concern for your privacy</li> <li>▪ Nurses sensitivity to the personal difficulties and inconvenience caused by your health problems</li> <li>▪ Staff concern to keep your family informed about your treatment, condition or progress (if you wanted them informed)</li> <li>▪ Degree of involvement you and your family have had in planning your home health care</li> <li>▪ Amount of attention the nurses paid to your own ideas about your care.</li> </ul> </li> <li>○ The Nurse Manager assigned to home health aide oversight will provide focus education in these Press Ganey indicators using Press Ganey tools developed to provide definition, "voice of the customer" and improvement tips with all HHAs within 30 days. Evidenced by completion of a case communication note and attendance sheet specific to that HHA and will be placed in the HHA</li> </ul>	10/28/07

10/19/07 acceptable  
Alicia Williams RN

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED:  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/05/2007
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NAME OF PROVIDER OR SUPPLIER  ST ELIZABETH CERTIFIED HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 14 FOERY DRIVE UTICA, NY 13501
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3A

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER

ST ELIZABETH CERTIFIED HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

14 FOERY DRIVE

UTICA, NY 13501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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*accept 10/10/07*  
*PW*

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2007  
FORM APPROVED  
OMB NO. 0938-0399

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/05/2007
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NAME OF PROVIDER OR SUPPLIER

ST ELIZABETH CERTIFIED HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

14 FOERY DRIVE  
UTICA, NY 13501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 101	Continued From page 3 agency had not submitted a referral to APS for this patient since 2005.  Not only did the agency fail to protect the patient's rights to be treated with respect and dignity but the agency also failed to follow-up on concerns regarding the patient's safety.  Furthermore, the Administrator's use of the term babysitting shows a lack of respect for this elderly patient and lacks sensitivity to the patient's clinical nursing needs.  Failure to ensure that the patient's are treated with respect and dignity may lead to unmet patient needs.	G 101		
G 116	484.10(f) HOME HEALTH HOTLINE  The patient has the right to be advised of the availability of the toll-free HHA hotline in the State.  When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.  This STANDARD is not met as evidenced by: Based on an observational home visit and interviews with the Administrator and the patient's caregiver (daughter), evidence is lacking that the patient's caregiver was afforded the right to	G 116	<ul style="list-style-type: none"> <li>The Acting Interim Administrator will retain responsibility for ensuring that the rights of all patients to be advised of the availability of the toll-free HHA hotline in the State</li> <li>Beginning 9/27/07 all staff will be re-educated by the Administrator and/or Nurse Manager on the purpose of the State hotline and the expectation that patients be advised of the availability of the hotline to lodge complaints or questions about the home health agency. A written educational piece will be provided and a signature page for completion will be obtained.</li> </ul>	Ongoing  10/30/07

*10/9/07 acceptable*  
*[Signature]*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  ST ELIZABETH CERTIFIED HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 14 FOERY DRIVE UTICA, NY 13501
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G 116 Continued From page 4  
access the toll free hotline to voice complaints or  
inquire about home health care services for the  
patient.

On 09/05/07, the surveyor conducted an  
observational home visit with the Administrator,  
the skilled nurse and the home health aide.  
During the visit, the Administrator stated that she  
wanted to clarify something with the daughter and  
the surveyor. The Administrator wanted to know  
if the patient's daughter was going to immediately  
call the New York State Department of Health  
(NYS DOH) with her complaints and bypass the  
agency. The patient's daughter did not respond to  
the Administrator's questioning.

The surveyor explained to the Administrator and  
the daughter that all patients have the right to call  
the NYS DOH to ask questions or voice concerns  
without fear of reprisal or discrimination.

Failure of the agency to protect the patient's  
ability to voice grievances regarding care and  
services may lead to poor care and negative  
outcomes.

G 159 484.18(a) PLAN OF CARE

The plan of care developed in consultation with  
the agency staff covers all pertinent diagnoses,  
including mental status, types of services and  
equipment required, frequency of visits,  
prognosis, rehabilitation potential, functional  
limitations, activities permitted, nutritional  
requirements, medications and treatments, any  
safety measures to protect against injury,  
instructions for timely discharge or referral, and  
any other appropriate items.

G 116

G 159

- The Acting Interim Administrator will retain  
overall responsibility for ensuring that all  
systems are in place to ensure that all  
patient symptoms are identified, addressed  
and immediately reported to the physician;  
that initial nursing assessments are  
complete, accurate, individualized; that  
supervisory functions are being performed  
and that effective communication and  
coordination between all discipline occurs;  
that the plan of care includes scope and visit  
frequencies of all services provided.
- The following actions have been  
implemented for the Start of  
Care/Resumption of Care/Recertification  
Process and are inclusive of a review of the  
HHA POC when applicable and identification  
of HHA needs if not addressed:

Ongoing

Ongoing

- Admitting clinician performs  
SOC/ROC/Recertification  
Assessment, selects the care  
protocol appropriate to the pt  
diagnoses and needs and  
individualizes it to the specific  
patient needs.
- Primary clinician contacts the  
physician regarding the Plan of  
Care, receives approval for the  
Plan of Care and clarifies any  
identified issues.
- Documentation of physician  
contact is made on the OASIS  
Assessment Form, Visit note,  
Case Communication note or  
Interim Order Form as appropriate.

*10/9/07 acceptable*  
*Paula Sullivan*

G 159

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/05/2007
NAME OF PROVIDER OR SUPPLIER  ST ELIZABETH CERTIFIED HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 14 FOERY DRIVE UTICA, NY 13501		
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G 159	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on a review of clinical record for patient #1 and interviews with the Administrator evidence is lacking that the agency developed an appropriate plan of care to ensure that all of the patient's needs were met.</p> <p>Failure to ensure a comprehensive plan of care is developed has the potential for unmet patient needs.</p> <p>Patient #1 was admitted to the agency on 07/23/06 with a primary diagnosis of an upper gastrointestinal bleeding and secondary diagnoses of cerebral vascular accident, hypothyroidism, dementia and replacement of the percutaneous endoscopic gastrostomy (PEG) tube.</p> <p>During the comprehensive re-assessment visit conducted on 05/18/07 the skilled nurse documented that the patient's daughter was unable to provide care to the patient.</p> <p>The plan of care that was developed dated 05/19/07 to 07/17/07, based on the 05/18/07 skilled nursing assessment failed to identify how the following patient care needs would be met if the caregiver (patient's daughter) was "unable to provide care."</p> <ul style="list-style-type: none"> <li>- the patient is bedfast - there is no plan to turn and position the patient</li> <li>- the patient has an indwelling foley catheter there is no plan for who will empty the catheter and provide catheter care</li> <li>- care of the PEG tube including cleansing of the</li> </ul>	G 159	<ul style="list-style-type: none"> <li>o Case conferences with Nurse Managers and primary clinician occur at SOC/ROC/ Recertification and are documented on a Case Conference Form at the time of the case conference.</li> <li>o Utilizing the SOC/ ROC/Recertification audit tool to trigger the Nurse Manager to review all areas of assessment and the plan of care development. 100% of all SOC/ROC/Recertification records will be reviewed within 72 business hours.</li> <li>o Areas found to be insufficient are reviewed and addressed with the individual clinicians by the Nurse Managers. This will be signed documenting that this took place.</li> <li>o Physician is contacted for additional clarifications as necessary and corrections are made by the primary clinician to the Plan of Care.</li> <li>o Final 485 review by the DPS/Nurse Manager or Designee for physician's review and signature will occur within 7 days.</li> <li>o The need to alert the physician when changes in the patient's condition suggest the need to modify the Plan of Care will be monitored during the bi-weekly case manager conferences, multidisciplinary case conferences</li> </ul> <p>• Ongoing monitoring will occur during the established clinical record review audits.</p>		

*acceptable Paula Williams RN*

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ST ELIZABETH CERTIFIED HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

14 FOERY DRIVE

UTICA, NY 13501

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G 159	<p>Continued From page 6 insertion site</p> <ul style="list-style-type: none"> <li>- the patient requires feeding assistance both oral and tube feedings 4 to 6 times a day by gravity. The plan of care does not address who will perform this care.</li> <li>- the patient requires the application of medicated creams to reddened areas of the buttocks. There is no plan to ensure that this is provided and no frequency for the application of these creams.</li> <li>- the patient is totally dependent on another for medication administration. There is no plan to ensure that the patient receives her medications.</li> </ul> <p>The plan of care did include aide service 7 days a week however, did not include the number of hours of aide services required to assist in meeting the patient's needs.</p> <p>Furthermore, there was no plan developed to address the patient's safety needs in light of the fact that the caregiver (patient's daughter) was unable to provide care.</p> <p>Although the agency was aware of the caregiver's inability to provide care to this patient on 05/18/07, there was no plan to increase service, or that a referral to an outside agency was initiated to ensure that the needs of the patient were met.</p> <p>On 07/13/07, the agency Administrator was informed by the New York State Department of Health that a complaint had been voiced to the surveyor that the agency was not providing the number of home health aide hours ordered by the</p>	G 159	<ul style="list-style-type: none"> <li>Process to review and/or revise the plans of care: <ul style="list-style-type: none"> <li>Nurse Manager are meeting bi-weekly with all RN case managers to complete the case conference summary record. Any need to change or revise the plan of care is addressed at this time. Ongoing reviews will continue to identify need for revisions to the plan of care.</li> <li>Plans of care will be reviewed by the DPS or designee prior to being mailed to the physician.</li> <li>SOC, Recertification and ROC audit process and tool have been implemented.</li> <li>Acting Interim Administrator will meet with the Management Staff (DPS, Nurse Manager(s) and Business Office Manager) on a weekly basis to provide additional over-site, on going education and training.</li> <li>SOC/Recertification/ROC Audits are being completed to monitor for adequacy and revisions to the plan of care as appropriate. In this review, the results are trended by the QA Nurse to identify any areas needing additional focus and in-service education.</li> </ul> </li> </ul>	Ongoing

10/10/07 Acceptable  
Paula J. Williams



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G 159	Continued From page 7 physician. The complaint alleges that the physician ordered 3 hours a day for 4 days and 2 hours a day for 2 days. The surveyor asked the Administrator how many hours of aide service the patient was receiving per visit? The Administrator stated that she thought that they were providing 2 to 3 hours of aide service daily.  During the 07/16/07 interview with the with the Administrator, she voiced her concerns regarding the patient's safety and the daughter's inability to provide care for this patient. The surveyor asked the Administrator if she had made a referral to Adult Protective Services (APS) to evaluate the patient's safety needs. The administrator stated that she made a referral to APS and that APS had no findings. A review of the clinical record was conducted on 09/05/07. The clinical record contained no documentation that a referral was made to APS to evaluate the safety of this patient. During an interview with the Administrator on 09/05/07, the Administrator confirmed that the she had not made a referral to APS since 2005 for this patient.  The most recent plan of care dated 07/18/07 to 09/15/07 contained orders for skilled nursing visits once a week and home health aide visits were now ordered 3 hours a day 7 days a week. However, there was still no evidence that a plan was developed to address the patient's needs when the caregiver (patient's daughter) was unable to provide care due to her own physical disabilities.	G 159	<ul style="list-style-type: none"> <li>In addition to the previously developed and implemented educational plan new in-services have been planned: <ul style="list-style-type: none"> <li>The following in-services are scheduled <ul style="list-style-type: none"> <li>A presentation for the Home Health Aides entitled "Patient Abuse: Role of the Para Professional" was presented by Clinical Nurse Consultant on September 25, 2007. Evaluation Tests were completed. 9/25/07</li> <li>By October 30, 2007 a representative from the Elder Abuse Committee of Oneida County will provide a presentation on recognizing and reporting elder abuse, and the role of Elder Abuse Committee of Oneida County 10/30/07</li> <li>By Oct 30, 2007, the Risk Manager, from St Elizabeth Medical Center and Member the Medical Center Ethics Committee will provide a presentation on complaint processing, complaint resolution and the role of the Ethics Committee in identifying appropriate actions when staff encounter</li> </ul> </li> </ul> </li> </ul>	
G 228	484.36(d)(1) SUPERVISION  If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d)(2) of this section.	G 228		

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G 159	<p>Continued From page 7</p> <p>physician. The complaint alleges that the physician ordered 3 hours a day for 4 days and 2 hours a day for 2 days. The surveyor asked the Administrator how many hours of aide service the patient was receiving per visit? The Administrator stated that she thought that they were providing 2 to 3 hours of aide service daily.</p> <p>During the 07/16/07 interview with the with the Administrator, she voiced her concerns regarding the patient's safety and the daughter's inability to provide care for this patient. The surveyor asked the Administrator if she had made a referral to Adult Protective Services (APS) to evaluate the patient's safety needs. The administrator stated that she made a referral to APS and that APS had no findings. A review of the clinical record was conducted on 09/05/07. The clinical record contained no documentation that a referral was made to APS to evaluate the safety of this patient. During an interview with the Administrator on 09/05/07, the Administrator confirmed that the she had not made a referral to APS since 2005 for this patient.</p> <p>The most recent plan of care dated 07/18/07 to 09/15/07 contained orders for skilled nursing visits once a week and home health aide visits were now ordered 3 hours a day 7 days a week. However, there was still no evidence that a plan was developed to address the patient's needs when the caregiver (patient's daughter) was unable to provide care due to her own physical disabilities.</p>	G 159	<p>questionable patient situations with unmet patient needs.</p> <ul style="list-style-type: none"> <li>A Self Paced Work Book for the Professional Clinicians Elder Abuse and Neglect will be distributed to the agency clinical staff on October 3, 2007 with completed competency test due October 13, 2007.</li> <li>Initiated on September 26, 2007, a copy of the Home Health Aide POC for each patient will be made and put into a single binder to be maintained by the Nurse Manager. The binder will be taken to IDT meetings, The Nurse Manager (MCP) will ensure patients discussed that have a Home Health Aide will have a review of their current HHA plan of care to assess for whether meeting patient needs or if interventions need to be modified.</li> <li>The clinical record for the patient identified in this report was reviewed. Conferences with staff identified as deficient in practice were held.</li> <li>Pt # 1 is now discharged from the agency and is receiving 24 hour nursing home care.</li> </ul>	10/13/07
G 228	<p>484.36(d)(1) SUPERVISION</p> <p>If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d)(2) of this section.</p>	G 228		

8A

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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G 228	<p>Continued From page 3</p> <p>If the patient is not receiving skilled nursing care, but is receiving another skilled service (that is, physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist.</p> <p>This STANDARD is not met as evidenced by: Based on a review of the clinical record for patient #1 and interviews with the Administrator and the home health aide, evidence is lacking that the agency is providing adequate supervision of the home health aide (HHA) to ensure that significant observations are documented and reported to the skilled nurse.</p> <p>Failure to ensure that the aide documents and reports significant findings has the potential for unmet patient needs.</p> <p>Patient #1 was admitted to the agency on 07/23/06 with a primary diagnosis of an upper gastrointestinal bleeding and secondary diagnoses of cerebral vascular accident, hypothyroidism, dementia and replacement of the percutaneous endoscopic gastrostomy (PEG) tube. A review of home health aide (HHA) documentation of daily visits from 05/18/07 to 08/15/07 was completed. There is no evidence that the HHA documented significant changes in skin integrity that was identified by the skilled nurse during scheduled skilled nursing visits. Examples of skin integrity changes identified by the skilled nurse are as follows:</p> <p>On 05/21/07, the skilled nurse documented that the patient's bottom was very red, weepy, and</p>	G 228	<p>G 228</p> <ul style="list-style-type: none"> <li>The Acting Interim Administrator will retain responsibility for ensuring adequate supervision of the home health aide services</li> <li>RN staff were re-educated by the Administrator in the morning staff meeting on the role of supervising aide services including following up on unreported findings with aide and notifying the Nurse Manager</li> <li>Records of 100% of patients currently receiving aide services were reviewed, care plans for home health aide personal services were compared with assessments and aide documentation. Results will be trended by QA Nurse and presented to the professional advisory committee for review.</li> <li>100% of HHA visit notes will be reviewed by the Nurse Manager for 45 days (end date 11/11/07) to identify variances from the personal care plan for home health aide services including frequency and expected duration. Appropriate counseling will be done up to formal disciplinary action with the oversight of the interim AD. <ul style="list-style-type: none"> <li>The ongoing monitoring will be done within the Clinical Record Review quarterly for 10% of records of patients receiving home health aide services.</li> <li>In addition, initiated on September 26, 2007, a copy of the personal care plan for Home Health Aide services for each patient will be made and put into a single binder to be maintained by the Nurse Manager. The binder will be</li> </ul> </li> </ul>	<p>Ongoing</p> <p>9/24/07</p> <p>9/28/07</p> <p>11/11/07</p> <p>9/27/07</p> <p>9/26/07/ ongoing</p>	

10/9/07 acceptable and

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- Admitting clinician performs SOC/ROC/Recertification Assessment selects the appropriate protocol and individualizes it to the specific patient needs.
- Primary clinician contacts the physician regarding the Plan of Care, receives approval for the Plan of Care and clarifies any identified issues.
- Documentation of physician contact is made on the OASIS Assessment Form, Visit note, Case Communication note or Interim Order Form as appropriate.

10/9/07 acceptable AM

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G 339	Continued From page 10  This STANDARD is not met as evidenced by: Based on a review of the clinical record for patient #1 and interviews with the agency Administrator, evidence is lacking that the agency is accurately completing an updated comprehensive assessment of the patient which reflects the current status of the patient.  Failure to provide a comprehensive re-assessment of the patient may lead to unmet patient needs.  Patient #1 was admitted to the agency on 07/23/06 with a primary diagnosis of an upper gastrointestinal bleeding and secondary diagnoses of cerebral vascular accident, hypothyroidism, dementia and replacement of the percutaneous endoscopic gastrostomy (PEG) tube. Although the skilled nurse completes a document labeled Adult Re-Assessment and OASIS Follow-up Assessment, the information contained in the documents completed on 05/18/07 and 07/16/07 failed to provide a complete and accurate description of the patient's status.  The comprehensive re-assessment document dated 05/19/07 failed to include the following:  - a complete assessment of the patient's ability to communicate. Specifically, the skilled nurse documented that there were no problems  - a complete assessment of the patient's neurological status. The skilled nurse documented that "no problems assessed"	G 339	<ul style="list-style-type: none"> <li>Case conferences with Nurse Managers and primary clinician occur at SOC/ROC/ Recertification and documented on a Case Conference Form.</li> <li>Utilizing the SOC/ ROC/Recertification audit tool to trigger the reviewer to review all areas of assessment and the plan of care development. 100% of all SOC/ROC/Recertification records will be reviewed within 72 business hours.</li> <li>Areas found to be insufficient are reviewed and addressed with the individual clinicians by the Nurse Managers. This will be signed documenting that this took place.</li> <li>Physician is contacted for additional clarifications as necessary and corrections are made by the primary clinician to the Plan of Care.</li> <li>Final 485 review by the DPS/Nurse Manager or Designee for physician's review and signature will occur within 7 days.</li> <li>The need to alert the physician when changes in the patient's condition suggest the need to modify the Plan of Care will be monitored during the bi- weekly case manager conferences, multidisciplinary case conferences</li> <li>Ongoing monitoring will occur during the established clinical record review audits.</li> </ul>	Ongoing

*10/9/07 acceptable*

*11/14*

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/05/2007
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UTICA, NY 13501

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G 339	Continued From page 11  - a complete assessment of the patient's musculoskeletal system. The skilled nurse documented that "no problems assessed" However, the patient is described as bedfast and unable to turn self. There is no assessment of the patient's upper body strength or ability to move her lower extremities.  - documentation of an assessment of the skin surrounding the PEG tube insertion site or documentation that the patient has a PEG tube for enteral feedings  - a description of the patient's nutritional status including the patient's ability to take food and fluid by mouth or an assessment of how the patient receives tube feedings 4 to 6 cans a day including the person responsible for this task.  - an assessment of the patient's neurological/emotional/behavioral status, the skilled documented "no problems assessed"  - an assessment of how the patient's needs are being met and identification of who is responsible for each aspect of care. Specifically, the skilled nurse documented that the daughter is unable to provide 24 hour care for the patient. There is no plan in place to meet the needs of the patient.  The comprehensive re-assessment document dated 07/16/07 failed to include the following:  - a complete assessment of the patient's neurological status. The skilled nurse documented that the patient was alert however, there is no assessment of the patient's orientation status.	G 339	<ul style="list-style-type: none"> <li>Process to review and/or revise the plans of care: <ul style="list-style-type: none"> <li>Nurse managers are meeting bi-weekly with all RN case managers to complete the case conference summary record. Any need to change or revise the plan of care is addressed at this time. Ongoing reviews will continue to identify need for revisions to the plan of care.</li> <li>Plans of care will be reviewed by the Nurse Manager prior to being mailed to the physician.</li> <li>SOC, Recertification and ROC audit process and tool have been implemented.</li> <li>Administrator or Interim Agency Director will meet with the Management staff on a weekly basis to provide additional oversight, on going education and training.</li> <li>SOC/Recertification/ROC Audits are being completed to monitor for adequacy and revisions to the plan of care as appropriate In this review, the results are trended to identify any areas needing additional focus and in-service education.</li> </ul> </li> <li>In addition to the previously developed and implemented educational plan new in-services have been planned: <ul style="list-style-type: none"> <li>The following in-services are scheduled <ul style="list-style-type: none"> <li>A presentation for the Home Health Aides</li> </ul> </li> </ul> </li> </ul>	Ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2007  
FORM APPROVE  
OMB NO. 0938-339

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/05/2007
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NAME OF PROVIDER OR SUPPLIER

ST ELIZABETH CERTIFIED HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE  
14 FOERY DRIVE  
UTICA, NY 13501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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G 339

Continued From page 12

- a complete assessment of the patient's musculoskeletal system. The skilled nurse documented that the patient had generalized weakness. However, the patient is also described as bedfast and unable to turn self. There is no assessment of the patient's upper body strength or ability to move her lower extremities.

- a complete assessment of the caregiver's (patient's daughter) ability to provide turning and positioning on a frequent basis.

- a complete assessment of the PEG tube insertion site including location and a description of the site.

- a description of the patient's nutritional status including the patient's ability to take food and fluid by mouth. An assessment of how the patient receives tube feedings 4 to 6 cans a day including the person responsible for this task.

Although the skilled nurse completed a comprehensive re-assessment document on 07/16/07, patient care needs were still unclear. The Administrator documented in a progress note dated 07/16/07 and informed the caregiver (patient's daughter) that the patient required 24-hour care. A review of the 07/16/07 skilled nursing comprehensive re-assessment is not of sufficient scope to support the Administrator's claim that the patient requires 24-hour care.

G 339

entitled "Patient Abuse: Role of the Para Professional" was presented by Clinical Nurse Consultant on September 25, 2007. Evaluation Tests were completed.

- By October 30, 2007 a representative from the Elder Abuse Committee of Oneida County will provide a presentation on recognizing and reporting elder abuse, and the role of Elder Abuse Committee of Oneida County 10/30/07
- By October 30, 2007, the Risk Manager, from St Elizabeth Medical Center and Member the Medical Center Ethics Committee will provide a presentation on complaint processing, complaint resolution and the role of the ethics committee in identifying appropriate actions when staff encounter questionable patient situations with unmet patient needs. 10/30/07
- A Self Paced Work Book for the Professional Clinicians Elder Abuse and Neglect will be 10/13/07

*12/19/07 acceptable Paula Williams RN #450*

*Bruna K. Raquel RN*



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/20  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/05/2007
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NAME OF PROVIDER OR SUPPLIER

ST ELIZABETH CERTIFIED HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

14 FOERY DRIVE

UTICA, NY 13501

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G 339	Continued From page 12  - a complete assessment of the patient's musculoskeletal system. The skilled nurse documented that the patient had generalized weakness. However, the patient is also described as bedfast and unable to turn self. There is no assessment of the patient's upper body strength or ability to move her lower extremities.  - a complete assessment of the caregiver's (patient's daughter) ability to provide turning and positioning on a frequent basis.  - a complete assessment of the PEG tube insertion site including location and a description of the site.  - a description of the patient's nutritional status including the patient's ability to take food and fluid by mouth. An assessment of how the patient receives tube feedings 4 to 6 cans a day including the person responsible for this task.  Although the skilled nurse completed a comprehensive re-assessment document on 07/16/07, patient care needs were still unclear. The Administrator documented in a progress note dated 07/16/07 and informed the caregiver (patient's daughter) that the patient required 24-hour care. A review of the 07/16/07 skilled nursing comprehensive re-assessment is not of sufficient scope to support the Administrator's claim that the patient requires 24-hour care.	G 339	distributed to agency's clinical staff on October 3, 2007 with completed competency test due October 13, 2007.  • Initiated Sept 26, 2007, a copy of the Home Health Aide POC for each patient will be made and put into a single binder to be maintained by the Nurse Manager. The binder will be taken to IDT meetings. The Nurse Manager (MCP) will ensure patients discussed that have a Home Health Aide will have a review of their current HHA plan of care to assess for whether meeting patient needs or if interventions need to be modified.  • The clinical record for the patient identified in this report was reviewed. Conferences with staff identified as deficient in practice were held.  • Pt # 1 is now discharged from the agency and is receiving 24 hour nursing home care.	9/26/07/ Ongoing       9/27/08

*Bruna K. Rangel RN*

13A

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>337081</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/05/2007</b>	
NAME OF PROVIDER OR SUPPLIER  <b>CORTLAND COUNTY HEALTH DEPARTMENT</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>60 CENTRAL AVE</b> <b>CORTLAND, NY 13045</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 000	INITIAL COMMENTS			G 000			
G 143	<p>484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 3 clinical records, interviews with agency staff, the Supervising Nurse and the Director of Patient Services, evidence is lacking in 1 record that all changes in the patient's plan of care are communicated to the on-call staff responsible to meet the needs of the patient. Patient #1</p> <p>Evidence is as follows:</p> <p>Patient #1 was admitted to the agency on 06/08/06 with diagnoses of neurogenic bladder, cystostomy, quadriplegia, and autonomic dysreflexia. The plan of care dated 12/05/07 to 02/02/07 states that the patient required private duty nursing (PDN) management of the patient's bowel program every Monday, Wednesday and</p>			G 143			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>CORTLAND COUNTY HEALTH DEPARTMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>60 CENTRAL AVE</b> <b>CORTLAND, NY 13045</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 143	<p>Continued From page 1</p> <p>Friday as staff are available. The care is provided at 5:30 am by a licensed practical nurse. On 11/15/06 and 11/17/06, the agency failed to provide the patient with her bowel care stating that the plan of care indicates that the care is to be provided if staff is available. Upon discussion with the surveyor regarding this plan of care, the agency contacted the physician and obtained a new order on 01/08/07 that states private duty nursing services are to be provided Monday, Wednesday and Friday as ordered.</p> <p>On 01/15/07, the private duty nurse called the agency stating that she could not provide care. The on-call skilled nurse notified the patient that the private duty nurse was not available to provide bowel care. The on-call nurse documented in the patient record that "advised her (patient) the order states if PDN is not available to do the bowel program public health nurse will do during normal business hours according to the orders on file." On 02/05/07, the surveyor interviewed the on-call nurse and confirmed this conversation between the nurse and the patient. The surveyor asked if she was aware that a new order was written on 01/08/07 that eliminates the requirement of providing care during normal business hour. The on-call nurse stated that she was unaware that the order had changed. There is no documentation that the on-call staff were informed of this change in the order. An interview with the Director of Patient Services (DPS) was conducted on 02/05/07. The DPS stated that the physician's order was in the chart and therefore the on-call nurse would have been aware of this change.</p> <p>Failure of the agency to ensure changes in the plan of care are communicated to all individuals</p>	G 143			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  <b>CORTLAND COUNTY HEALTH DEPARTMENT</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>60 CENTRAL AVE</b> <b>CORTLAND, NY 13045</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 143	Continued From page 2 responsible for providing care has led to failure of the agency to provide bowel care for this patient when the PDN is unavailable.			G 143			

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FORM APPROVED  
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

137284

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

C

07/08/2007

RECEIVED

SEP 20 2007

NAME OF PROVIDER OR SUPPLIER

HOSPITALS HOME HEALTH CARE HHA

STREET ADDRESS, CITY, STATE, ZIP CODE  
113 SCHUYLER STREET, SUITE 3  
FULTON, NY 13069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	NYS Dept. of Health (X5) REGIONAL COMPLETION DATE
G 000	INITIAL COMMENTS  This Statement of Deficiencies is the result of complaint investigation #NY00041621. During the complaint investigation the surveyor interviewed staff, the Director of Patient Services, and reviewed the patient's hospital medical record for admission dates 01/22/07 to 01/26/07.	G 000		
G 118	484.12(a) COMPLIANCE WITH FED, STATE, LOCAL LAWS  The HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations. If State or applicable local law provides for the licensure of HHAs, an agency not subject to licensure is approved by the licensing authority as meeting the standards established for licensure.  This STANDARD is not met as evidenced by: The New York State Code of Rules and Regulations pertaining to Certified Home Health Care Agencies 10NYCRR 763.5 (d) Patient Referral and Admission are as follows:  "Any patient who is assessed or reassessed as inappropriate for agency services shall be assisted by the agency, in collaboration with the discharge planner, the local Social Service Department and other case management entity, as appropriate, with obtaining the services of an alternate provider, if needed, and the patient's authorized practitioner shall be so notified. If alternate services are not immediately available, and the local Protective Services for Adults Program, the Office of Mental Retardation and Developmental Disabilities, the Office of Mental Health or other official agency requests that home care services be provided on an interim basis, the agency may provide home care services which address minimally essential patient health and safety needs for a period of time agreed upon by the agency and the requesting entity,	G 118	SN was counseled and re-educated to the admission/resumption of care process per agency policy and home care regulations which included: <ul style="list-style-type: none"><li>a comprehensive assessment with home safety assessment</li><li>OASIS completion</li><li>Care plan development to assure basic care needs are planned for and in place for patient safety</li><li>Communication with DPS/covering administrators when safety concerns or unmet needs are identified.</li></ul> Responsible Person(s): Melissa Allard, HHHC DPS  9/20/07 acceptable Paul Williams RW HHC	6/14/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



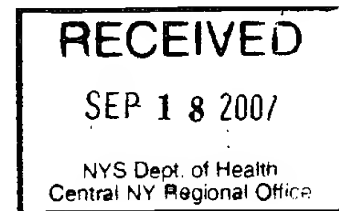
**Certified Home Health Care Agency**

A Partnership of A.L. Lee Memorial Hospital, Oswego Hospital and St. Joseph's Hospital Health Center

*Paula*  
*9/18/07*  
113 Schuyler Street, Suite 3  
Fulton, New York 13069  
(315) 598-1544  
(866) 625-4392  
Fax (315) 598-6868

September 14, 2007

Lynn Shannon  
Home and Community Based Program Manager  
New York State Department of Health  
217 South Salina Street  
Syracuse, New York 13202



Dear Ms. Shannon:

Enclosed is the updated Plan of Correction.

Please do not hesitate to contact me at 598-1544 if you have any questions or need further information.

Respectfully,

Melissa Allard, RN  
Director of Patient Services  
Hospitals Home Health Care, Inc.

cc: Mark Murphy, Administrator  
Connie Seiter

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 18/28/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337284	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/09/2007
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NAME OF PROVIDER OR SUPPLIER  HOSPITALS HOME HEALTH CARE HHA	STREET ADDRESS, CITY, STATE, ZIP CODE 113 SCHUYLER STREET, SUITE 3 FULTON, NY 13069
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS  This Statement of Deficiencies is the result of complaint investigation #NY00041621. During the complaint investigation the surveyor interviewed staff, the Director of Patient Services, and reviewed the patient's hospital medical record for admission dates 01/22/07 to 01/26/07.	G 000		
G 118	484.12(a) COMPLIANCE WITH FED, STATE, LOCAL LAWS  The HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations. If State or applicable local law provides for the licensure of HHAs, an agency not subject to licensure is approved by the licensing authority as meeting the standards established for licensure.  This STANDARD is not met as evidenced by: The New York State Code of Rules and Regulations pertaining to Certified Home Health Care Agencies 10NYCRR 763.5 (d) Patient Referral and Admission are as follows:  "Any patient who is assessed or reassessed as inappropriate for agency services shall be assisted by the agency, in collaboration with the discharge planner, the local Social Service Department and other case management entity, as appropriate, with obtaining the services of an alternate provider, if needed, and the patient's authorized practitioner shall be so notified. If alternate services are not immediately available, and the local Protective Services for Adults Program, the Office of Mental Retardation and Developmental Disabilities, the Office of Mental Health or other official agency requests that home care services be provided on an interim basis, the agency may provide home care services which address minimally essential patient health and safety needs for a period of time agreed upon by the agency and the requesting entity.	G 118	SN was counseled and re-educated to the admission/resumption of care process per agency policy and home care regulations which included: <ul style="list-style-type: none"> <li>a comprehensive assessment with home safety assessment</li> <li>OASIS completion</li> <li>Care plan development to assure basic care needs are planned for and in place for patient safety</li> <li>Communication with DPS/covering administrators when safety concerns or unmet needs are identified.</li> </ul> Responsible Person(s): Melissa Allard, HHHC DPS  6/20/07 acceptable Paula J. Williams RN Hospital	6/14/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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PRINTED: 12/13/2004  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337284	(X2) MULTIPLE CONSTRUCTION C. BUILDING _____ D. WING _____	(X3) DATE SURVEY COMPLETED C 07/09/2007
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NAME OF PROVIDER OR SUPPLIER  HOSPITALS HOME HEALTH CARE HHA	STREET ADDRESS, CITY, STATE, ZIP CODE 113 SCHUYLER STREET, SUITE 3 FULTON, NY 13069
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 118	<p>Continued From page 1</p> <p>provided that the patient and family or informal supports, as appropriate, have been fully informed of the agency's intent to transfer the patient to an alternate service, when available, and have been consulted in the development of an interim plan of care."</p> <p>Based on a review of documentation for patient #1, received from the hospital record for inpatient stay from 01/22/07 to 01/26/07, the initial home care nursing assessment documentation dated 01/27/07, and interviews with the Intake Coordinator and the Director of Patient Services (DPS), evidence is lacking that the agency developed a plan to ensure that the patient's needs could be safely met at home. The skilled nurse after conferring with her supervisor failed to initiate home care services and left the patient in her home knowing that she was unable to meet her own basic needs and lacked a primary caregiver who was able to assist.</p> <p>Failure to develop a plan for this patient has led to the patient not receiving home care services and the potential for patient harm.</p> <p>Specifically, patient #1 was admitted to the agency on 11/28/06 with a diagnosis of liver cancer. On 01/22/07, the patient was admitted to the hospital for dehydration and discharged from the hospital on 01/26/07. An admission assessment visit was conducted by the skilled nurse (SN) on 01/27/07. The SN documented in the clinical record that when she arrived at the patient's home the patient was: Incontinent of urine; unable to independently get up from the couch; and there was no caregiver able to assist the patient. The SN made a determination that the patient was inappropriate for home care services and failed to address the following patient care needs:</p>	G 118		



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER

HOSPITALS HOME HEALTH CARE HHA

STREET ADDRESS, CITY, STATE, ZIP CODE

113 SCHUYLER STREET, SUITE 3  
FULTON, NY 13069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 118	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>- the mechanism by which the patient would obtain her medications, including Coumadin (a blood thinner)</li> <li>- a mechanism for the patient to obtain and prepare food</li> <li>- how the patient would exit the home in case of an emergency situation</li> <li>- how the patient would ambulate to the bathroom</li> </ul> <p>During the visit, the SN called the physician to report that the agency was not going to admit the patient and that the SN felt that patient should be back in the hospital. The physician did not agree with the nurse and refused to readmit the patient to the hospital for complaints of urinary incontinence.</p> <p>The SN failed to develop a plan to provide even minimal care for this patient and no alternate services were provided.</p> <p>This record was discussed with the DPS on 04/06/07 and 06/12/07. No additional information was provided.</p>	G 118	<p>Agency-wide education with review of this case will be provided and include: - 9/20/07 - mtg</p> <ul style="list-style-type: none"> <li>- Admission/ROC process</li> <li>- CMS/NYS DOH regulations specific to the provision of care to meet basic needs when an unsafe situation exists and admission and assessment criteria</li> <li>- Regulatory intent to assure patient safety</li> <li>- Completion of comprehensive assessment</li> <li>- OASIS completion</li> <li>- Care planning to meet patient needs</li> <li>- Coordination of services</li> <li>- Problem solving to meet essential patient needs</li> <li>- Clear communication with agency administrative staff when concerns are identified.</li> </ul> <p>Responsible Person(s): Melissa Allard, HHC DPS</p> <p>9/20/07 - acceptable</p> <p>Paula Williams RN HNSC</p>	<p>9/30/07</p> <p>Staff Per 9/20/07</p> <p>TC. Melissa Allard DPS -</p>
G 159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on a review of documentation in the hospital record for inpatient stay from 01/22/07 to 01/26/07, the home care initial nursing assessment dated 01/27/07, and interviews with</p>			

FORM APPROVED  
OMB NO. 0938-0391

113 SCHUYLER STREET, SUITE 3  
FULTON, NY 13069.

6/14/07 and  
ongoing

9/00/07 - acceptable Paula Williams  
HNSC

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337284	(X2) MULTIPLE CONSTRUCTION I. BUILDING _____ J. WING _____	(X3) DATE SURVEY COMPLETED C 07/09/2007
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NAME OF PROVIDER OR SUPPLIER  HOSPITALS HOME HEALTH CARE HHA	STREET ADDRESS, CITY, STATE, ZIP CODE 113 SCHUYLER STREET, SUITE 3 FULTON, NY 13069
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 4  The skilled nurse left the patient's residence without ensuring that a plan was in place to meet the patient's needs.  This record was discussed with the DPS on 04/06/07 and 06/12/07. No additional information was provided.	G 159		
G 340	484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT  The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.  This STANDARD is not met as evidenced by: Based on a review of the clinical record, information for patient #1 and interviews with the Director of Patient Services (DPS), evidence is lacking that the agency completed a comprehensive assessment of the patient's needs upon discharge from the hospital as follows:  Patient #1 was admitted to the agency on 11/28/06 with a primary diagnosis of liver cancer and secondary diagnoses of generalized weakness, nausea, neoplasm related pain and esophageal reflux. On 01/22/07, the patient was admitted to the hospital with dehydration. On 01/26/07, the home care agency's Intake Coordinator (a nurse employed by the agency to assess and screen patient's for agency admission) was informed that the patient would be discharged from the hospital today (01/26/07). The hospital record was reviewed by the surveyor on 06/12/07. In the progress notes section of the hospital record dated 01/26/07, the hospital case manager documented "the home care nurse coordinator is here to explain palliative care to the patient, all information given to the agency (home care agency)".	G 340	See G 118 and G 159. DPS/covering administrator to review all Seen not Admitted patients with staff at time of in-home assessment to ensure appropriateness of destination and ensure patient has adequate plan in place to be safe. Seen Not Admitted patients will be trended monthly and reported quarterly to the Professional Advisory Committee.  Responsible Person(s): Melissa Allard, HHC DPS Kathy Phillips, CHHA PI Specialist Helen Dalaker, CHHA Manager PI/Education  See G 118  9/20/07 acceptable Paula Williams HNHC	6/14/07 and ongoing

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NAME OF PROVIDER OR SUPPLIER

HOSPITALS HOME HEALTH CARE HHA

STREET ADDRESS, CITY, STATE, ZIP CODE

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FULTON, NY 13069

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G 340	<p>Continued From page 5</p> <p>On 01/27/07 at 10:40 a.m., the home care agency skilled nurse (SN) visited the patient to conduct an initial admission assessment (not a resumption of care assessment). The SN documented that she began her assessment and noted that the patient was lying on a urine soaked couch. The SN also documented that the patient was unable to stand with her walker and assistance of 1 person. The SN and the patient's brother (who just had surgery) assisted the patient to stand and ambulate. The SN then provided the patient with personal care and determined that the patient could not be admitted to the agency.</p> <p>The SN documented that she called the patient's physician and explained that the patient needed to be readmitted to the hospital due to safety concerns. The SN documented on the visit note 01/27/07 that "MD (physician) does not plan on admitting her (back to the hospital) because she is lying in urine". The skilled nurse failed to complete the home care initial comprehensive assessment including the following: vital signs, cardiopulmonary, genitourinary, gastrointestinal system, availability of medications (including Coumadin), nutritional status including the availability of food and fluids.</p> <p>The skilled nurse failed to perform a complete assessment of the patient and the patient was left with no plan to ensure that she was safe in her home without home care services.</p> <p>The skilled nurse did, however, discuss the patient's status with the DPS during the admission visit. The DPS stated that the agency "cannot open to services and we (the agency) will alert MSW (Medical Social Work) on Monday (01/29/07) and make a call to Adult Protective".</p>	G 340	See G 159	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  HOSPITALS HOME HEALTH CARE HHA	STREET ADDRESS, CITY, STATE, ZIP CODE 113 SCHUYLER STREET, SUITE 3 FULTON, NY 13069
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G 340	<p>Continued From page 6</p> <p>On 06/21/07, the surveyor spoke to the DPS to discuss the above findings. The surveyor asked for clarifications regarding why care was not resumed on the day of discharge from the hospital. The DPS stated that the agency does not make visits to the patients on the same day as discharge from the hospital. The DPS also stated that when the patient was assessed on 01/27/07, the 60 day certification period had expired. Therefore, the patient was assessed as a new admission and due to the lack of a caregiver and incontinence identified during the admission process, the patient did not meet the requirements for admission to the agency.</p> <p>Failure of the skilled nurse to complete a comprehensive assessment of the patient resulted in the patient's needs not being met.</p>	G 340		



MENORAH  
PARK

RECEIVED

JAN 28 2010

NYS Dept. of Health  
Central NY Regional Office

January 27, 2010

Lynn Shannon  
Home Care Program Manager  
NYS Department of Health  
217 South Salina Street  
Syracuse, NY 13202

Agency: Menorah Park Home Care Agency

Event #: R75W11

License #: 1193L001

Type of Survey: Fully Survey and **Complaint #s: NY00078274, NY000778695 & NY000778982**

Survey Exit Date: December 17, 2009

Plan of Correction Due Date: **December 31, 2009**

Dear Lynn:

Enclosed please find our revised Plan of Correction for Menorah Park Home Care. The credible allegation of compliance as requested in the attached document.

Feel free to contact me at (315) 446-9111 ext. 114 if you have any questions.

Best regards,

Mary Ellen Bloodgood  
Chief Executive Officer

MEB/kh

Enclosure

*Living and Caring in the Jewish Tradition*

Jewish Health & Rehabilitation Center • Rothschild Adult Day Program • Ahavath Achim Apartments

The Oaks Retirement Community • The Inn Assistive Living • Hospice Care and Respite Care

Hodes Way • 4101 East Genesee Street • Syracuse, New York 13214 • (315) 446-9111

NYS Dept. of Health  
Central NY Regional Office

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0318A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2009</b>
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INORAH PARK HOME CARE AGENCY

4101 EAST GENESEE STREET  
SYRACUSE, NY 13214

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H 000	Continued From page 1  just a nursing home"; "palliative care...we are not just a place, but also a philosophy of care...we offer emotional, physical and spiritual guidance for the individual and family members".  The survey resulted in significant deficiencies in the following areas: patient rights; patient assessments; plan of care development; supervision of patient care; staff orientation and training, and emergency preparedness. Negative outcomes (death) were identified for four patients: # 9, 10, 13, and 14.	H 000		
H 204	766.1(a)(1) Patient rights  Section 766.1 Patient rights.  (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to:  (1) be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record;  (2) be given a statement of the services available by the agency and related charges;  (3) be advised before care is initiated of the extent to which payment for agency services may be expected from any third party payors and the extent to which payment may be required from the patient.  (i) The agency shall advise the patient of any changes in information provided under this	H 204	<u>Correction</u> A written patient rights statement has been developed to meet 10NYCRR 766.1 standard.  Pieces that were revised: • Informed of Patient Rights • Rights to exercise such rights • Rights in writing prior to care • Written documentation in the clinical record • Given a statement of services and related charges • Agency shall advise the patient of any changes in information provided no later than 30 calendar days from date agency is aware of change • Information is provided verbally and in writing • All services agency is to provide, when and how services are to be provided • Name and function of any person and affiliated agency providing care and services <u>Protection of Others</u> This patient rights statement has been given to, discussed and received by all present patients. This is documented in their clinical records. The statement will be reviewed at each re-assessment of patient.	<u>Responsible Party:</u> Administrator 12/30/09  <u>Responsible Party:</u> Case Manager 01/12/10

1/29/10 acceptable. Pauline Williams RN



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0318A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2009</b>
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**INORAH PARK HOME CARE AGENCY****4101 EAST GENESEE STREET  
SYRACUSE, NY 13214**

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H 204	<p>Continued From page 2</p> <p>paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change.</p> <p>(ii) All information required by this paragraph shall be provided to the patient both orally and in writing;</p> <p>(4) be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services. This Regulation is not met as evidenced by: Based on a review of 16 patient records, interviews with the Director of Home Care, and agency staff, there is a lack of evidence in 16 (100%) records that patient/family was informed of the services the agency is to provide; was given a statement of charges associated with these services and was informed of when and how these services will be provided.</p> <p>Failure of the agency to inform the patient/family of the services available and how these services will be implemented has resulted in the patient/family's inability to make an informed decision regarding the patient's plan of care.</p> <p>Specifically, the agency failed to:</p> <ul style="list-style-type: none"> <li>o identify patient specific needs during the initial nursing assessment</li> <li>o identify changes in patient needs during skilled nursing re-assessments</li> <li>o develop a complete and comprehensive plan of care that addresses the patient's complex physical and cognitive needs</li> </ul>	H 204	<p><i>1/24 accept. Fullway</i></p> <p><u>Prevention of Reoccurrence</u> Adherence to this policy is being monitored by 100% of clinical record review for January, February and March 2010 to identify compliance, trends and issues and reported monthly at QA and then reevaluated per QA policy and procedures.</p> <p><u>Inservice</u> Patient Rights Statement was reviewed with all current staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new hires.</p>	<p><u>Responsible Party</u> Administrator 01/12/10</p> <p><u>Responsible Party</u> Administrator and Director of Home Care 01/05, 01/06 &amp; 01/07/10</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0318A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2009</b>
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MENORAH PARK HOME CARE AGENCY

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H 204	Continued From page 3  o discuss the plan of care with the patient/family and inform them of how these needs will be met  o provide the patient and family with a statement of all charges for these services prior to the initiation of care.  On 10/23/09, during an interview with the Director of Home Care, the surveyor requested copies of the statements of services and charges that were given to the patients and families. As of 11/10/09, the information was not provided to the surveyor	H 204		
H 216	766.1(a)(5) Patient rights  Section 766.1 Patient rights.  (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to:  ..... (5) participate in the planning of his or her care and be advised in advance of any changes to the plan of care. This Regulation is not met as evidenced by: Based on a review of 16 patient records and an interview with the Director of Home Care, evidence is lacking in 16 (100%) records that patients are offered the opportunity to participate in the planning of their care and that patients are advised of any changes to the plan of care. Patients 1-16  Failure of the agency to offer patients the opportunity to participate in the planning of their	H 216	<i>1/29/10 acceptable</i>  <u>Correction</u>  A new/revised policy/procedure for Patient Rights has been developed to meet and implement the requirements of 10NYCRR 766.1 (a)(5) standard.  •Participate in the planning of his/her care and be advised in advance of any changes to the Plan of Care.  <u>Protection of Others</u>  All present patients have had a new comprehensive assessment completed and their Plan of Care reviewed and updated. The Plan of Care has been reviewed with patient/family for their input. This is documented in the clinical records.	<u>Responsible Party:</u> Administrator 12/30/09  <u>Responsible Party:</u> Case Manager 01/19/10

STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  LC0318A	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/17/2009
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	12/17/2009
MEMORAH PARK HOME CARE AGENCY	4101 EAST GENESEE STREET SYRACUSE, NY 13214	

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H 216	Continued From page 4  care may lead to unmet patient needs and possible negative patient outcomes.  The surveyor interviewed and reviewed this information with the Director of Home Care on 11/2/09. No new evidence was provided.	H 216	<u>Prevention of Reoccurrence</u>  Adherence to this policy is being monitored by 100% chart review on present patients and all new admissions in January, February and March 2010, reported at QA monthly, then monitored according to our QA policies and procedures with random chart reviews.  <u>Inservice</u>  New policy has been reviewed with all current staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new licensed staff.  <u>Correction</u>  A written policy/procedure and documentation sheet has been developed to meet 10NYCRR 766.2  •Written policies and procedures with current professional standards of practice •Deliver of each service is documented in the clinical record •To extent possible services are provided by same person •Display proper identification •Storage of supplies •Evaluation of equipment •Procedure for new services •Discharge plan  <u>Protection of Others</u>  All current patients/families have had all relevant policies/procedures reviewed with documentation of this review in the clinical record. This review with current patients/families included Advance Directives.	<u>Responsibility Party:</u> Case Manager 01/15/10  <u>Responsibility Party:</u> Director of Home Car & Administrator 01/15/10  <u>Responsible Party:</u> Administrator / Director of Home Care 01/11/10  <u>Responsible Party:</u> Case Manager 01/11/10
H 304	766.2(a)(1) Patient service policies and procedures  766.2 Patient service policies and procedures.  (a) The governing authority shall ensure for each health care service provided that:  (1) written policies and procedures consistent with current professional standards of practice are developed and implemented for each service and are reviewed and revised as necessary; This Regulation is not met as evidenced by: Based on a review of 5 records for patients who had died within the past 13 months while on service in the home care agency, policies and procedures and interviews with agency staff, there is no evidence in 5 records (100%) that the agency implemented standards of practice for end of life care. Patients # 8, 9, 10, 13, 14.  o In 2 of 2 records reviewed for patients who died between September 2008 and November 2008, the agency failed to initiate measures to provide emergency medical care (activating 911) for patients who did not have a physician's order for DNR (Do Not Resuscitate). Patient's # 9, 10.  1. Patient # 10 was admitted to the agency on 07/06/06 with diagnoses of dementia, seizures and syncope. The patient resided on the locked dementia unit. The patient record contains conflicting information regarding the patient's date	H 304  <i>1/29/10 accepted by Pauline Williams</i>		

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NAME OF PROVIDER OR SUPPLIER  ENORAH PARK HOME CARE AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 EAST GENESEE STREET SYRACUSE, NY 13214	

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H 304	<p>Continued From page 5</p> <p>of death. Specifically, the home health aide documented in the activity record that the patient "passed away" during the evening shift on 11/19/08. The RN case manager documented that the patient passed away on 11/20/08. The RN case manager failed to document the time of death and who found the patient.</p> <p>Further review of the patient record identified that the patient did not initiate an advanced directive for Do Not Resuscitate (DNR). There is no evidence in the patient record that in the absence of a DNR order emergency care was initiated (911 called). Additionally, there was no documentation of who pronounced the patient dead.</p> <p>This record was discussed with the Director of Home Care on 10/29/09 who stated that this issue occurred before she was Director and that this is why they developed the policy on "Pronouncement of Death" in February 2009.</p> <p>2. Patient # 9 was admitted to the agency on 06/04/07 with a diagnosis of dementia and hypertension. The patient record failed to contain documentation that emergency care was initiated (911 called) when changes in the patient condition were brought to the attention of the Director of Home Care. The patient record contained an undated document written by the Director of Home Care labeled "Reason for Referral/Discharge - expired". The Director of Home Care failed to document the date or time of death; the person that found the patient and how the patient was found. The only date on the document was the date that the physician was notified of the death ( 09/25/09). There was no documentation in the patient record that the patient had initiated an advanced directive for Do</p>	H 304	<p><i>Y09/10 accepted by JFW</i></p> <p><u>Prevention of Reoccurrence</u> Adherence to this policy is being monitored by 100% of clinical record review for January, February and March 2010, reported monthly at QA for compliance, trends and issues, then reevaluated as per QA policies and procedures. Case Manager is responsible for tallying audits, identifying trends and submitting a summary monthly at QA.</p> <p><u>Inservice</u> New policy has been reviewed with all current licensed staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new licensed staff.</p> <p>Responsible Party: Case Manager 01/15/10</p> <p>Responsible Party: Director of Home Care &amp; Administrator 01/12/10</p>	

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H 304	<p>Continued From page 6</p> <p>Not Resuscitate and no documentation that emergency care was initiated (911 called) when the patient's condition deteriorated.</p> <p>The patient record contained a late entry progress note that was not entered into the record until 12/15/08, 3 months after the patient's death. The late entry progress note was written by the Director of Home Care and stated "late entry summary for 09/25/08 7 am to 8 am". The Director of Home Care documented that she was called by the home health aide to assess a change in the patient's mental status. The Director failed to document an assessment of the patient's status. The Director documented that she called the physician (who was the son-in-law) and "explained assessment findings." The Director documented "the physician spoke to his wife, the health care proxy and they did not want to send (the patient) to the hospital even though the reported findings were indication of end of life." The Director of Home Care called the physician/son-in-law again to report that end of life was imminent, however, the Director failed to document the assessment and failed to initiate calling 911 in the absence of a DNR order. The decision not to follow standards of practice for emergency treatment was solely based on a verbal discussion with the patient's physician/son-in-law. There was no evidence that the Director of Home Care spoke with the patient's health care proxy.</p> <p>This record was discussed with the Director of Home Care on 10/29/09 who stated that this issue was before she was Director and that this is why they developed the policy on "Pronouncement of Death" in February 2009.</p> <p>Failure to initiate resuscitation efforts for patients</p>	H 304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0318A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2009</b>
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**ENORAH PARK HOME CARE AGENCY****4101 EAST GENESEE STREET  
SYRACUSE, NY 13214**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 304	<p>Continued From page 7</p> <p>without Advanced Directives for Do Not Resuscitate resulted in negative outcomes (death) for patients # 9 and 10.</p> <p>The failure to implement agency specific policies and procedures developed in February 2009, has resulted in a failure to ensure that questionable circumstances surrounding patient deaths were adequately investigated for 2 patients who were "found" by agency staff dead. A third patient record failed to contain any documentation of her death.</p> <p>In 3 of 3 records reviewed for patients who died in the October 2009, interviews with agency staff and policy and procedure review, there is no evidence in 3 records (100%) that agency staff followed policies and procedures regarding patient assessments and reporting at the time of death.</p> <p>Examples are as follows:</p> <p>On 10/26/09, during an interview with the Director of Home Care, surveyor requested a copy of the agency's policy and procedure for care of the patient who is found unresponsive or without a pulse or respiration. The Director of Home Care provided the surveyor with a policy dated "02/09" labeled "Pronouncement of Death". The policy states that if the patient is a "full code, 911 is called. If the patient is pulseless and breathless with a DNR the physician is notified with details of how the resident was found, any falls within 30 days and asked if he would like to sign the death certificate or does he want the Medical examiner's office notified. Information requested by the ME's office will be supplied accordingly."</p> <p>The agency failed to follow the above procedure</p>	H 304		

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

LC0318A

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

C

12/17/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ENORAH PARK HOME CARE AGENCY

4101 EAST GENESEE STREET  
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H 304	<p>Continued From page 8</p> <p>in the following examples:</p> <p>1. Patient #13 was admitted to the agency on 04/10/05 with a diagnosis of dementia. The clinical record contained a progress note dated 10/03/09 at "2230" (10:30 pm) written by the Supervising RN from the skilled nursing facility and stated that the patient had died. The RN documented that the patient was found unresponsive by the home health aide on rounds had no pulse, heartbeat or respirations. The RN failed to document how the patient was found or how the death occurred.</p> <p>Surveyor interviews conducted between 10/26/09 and 11/06/09, with agency staff identified that the patient had sustained significant injuries from her head being stuck in the siderails. The staff informed surveyors that the patient's head was "stuck in between the siderails, and her legs were off the bed with her feet touching the floor" Additionally, staff informed the surveyor that the patient's head was stuck between the siderails and they had a difficulty getting her head out of the siderails. All staff interviewed by the surveyor verified the existence of siderails on the bed, although there is no evidence in the patient record of such.</p> <p>There was no evidence in the patient record that the patient was checked at anytime during the evening of her death or that any care was provided.</p> <p>On 11/10/09, the surveyor interviewed the Administrator, and informed her that there was no documentation of communication with the physician to report the patient's death. The surveyor asked where the information would be</p>	H 304	<p>Investigation completed to extent possible. Investigation report kept in Director of Home Care office.</p> <p style="text-align: right;">Responsible Party Director of Home Care 12/21/09</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>GENORAH PARK HOME CARE AGENCY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4101 EAST GENESEE STREET SYRACUSE, NY 13214</b>	

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H 304	<p>Continued From page 9</p> <p>documented? The Administrator stated that it would be in the record, she knows that the RN must have called and "just didn't document it." As of 11/20/09, no documentation was provided to the surveyor.</p> <p>On 11/24/09, the surveyors interviewed the Director of Home Care regarding her knowledge of the patient's death. The Director of Home Care stated that she called by the SNF Supervisor at the time of the patient's death. The Director of Home Care stated that she came in to the agency to assist the SNF Supervisor. The surveyor asked the Director if this was normal procedure for a patient death on off hours. She stated no but did not explain why she came in when this patient died.</p> <p>The surveyor asked the Director if she questioned staff regarding how the patient found, as outlined in the agency's policy "Pronouncement of Death dated 02/09." The Director stated that she did not ask staff, but the SNF Supervisor told the Director that the "patient was on the side of the bed somehow" The Director stated that she asked the SNF Supervisor if there was a "problem" and the Supervisor stated "no". The Director stated that she did not speak to any other staff about the position of the patient when she was found.</p> <p>The surveyor asked if she went in the patient's room and looked at the patient? The Director stated yes "when I saw her - she was in bed, no marks, no evidence she had a traumatic death" The surveyor asked the Director to clarify what she ment by marks or traumatic death? The Director stated "I just didn't see any marks, I only saw her upper body, I didn't look at her back."</p>	H 304		



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H 304	<p>Continued From page 10</p> <p>The surveyor asked the Director of Home Care if anyone had contacted the physician the evening that the patient died 10/03/09. The Director stated that she called him that night. The surveyor asked where that was documented and what time she called? The Director stated that she didn't document the call and that she spoke to "someone" at about 11 pm. The surveyor contacted the physician on 12/01/09 to determine the time of the call and received conflicting information.</p> <p>Specifically, on 12/01/09, 2:25 pm, the surveyor contacted the patient's primary physician and asked if he received a phone call on 10/03/09 informing him that the patient had died. He stated that he did not, but looking through his patient's record found "a note dated 11/04/09 at 02:18 pm - FYI Ms.... passed away 10/03/09". This is a contradiction of the information provided to the surveyor by the Director of Home Care on 11/24/09.</p> <p>2. Patient # 14 was admitted to the agency on 11/19/07 with a diagnosis of schizophrenia. The patient record contained a document labeled "Progress Note", written by the Director of Home Care, and dated 10/13/09. The document identified the reason for the note was "death", however, the note lacked the time of death, the physical condition when found and any injury that the patient may have sustained.</p> <p>Specifically, through interviews with agency staff, the surveyor was informed that the patient was found by another patient walking by the patient's room and that the patient sustained a forehead laceration and hematoma above the laceration. This information was not documented in the patient record and conflicting information was</p>	H 304	<p>Internal investigation completed to extent possible. Investigation file kept in Director of Home Care office.</p> <p style="text-align: right;"><u>Person Responsible:</u> Director of Home Care 12/28/09</p>	

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NAME OF PROVIDER OR SUPPLIER  NORAH PARK HOME CARE AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 EAST GENESEE STREET SYRACUSE, NY 13214	

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H 304	<p>Continued From page 11</p> <p>obtained through interviews with agency nursing staff who were assigned to place the patient back to bed after her death.</p> <p>The surveyor interviewed the Senior Living Coordinator on 11/10/09 who stated that on 10/13/09 around lunch time, she was summoned by a patient who stated that someone "fell". The Senior Living Coordinator stated that she went into the doorway of the patient's room called her name and she did not answer. The coordinator stated that she saw the patient on the floor with her face away from the door with food strewn around her face. The Coordinator who is not a nurse called the RN Administrator for help. The Senior Living Coordinator stated that she left the room and only returned to help clean up the blood and food from the floor after the patient was in bed and before the patient's family came in.</p> <p>On 11/10/09, the surveyor interviewed the RN Administrator regarding her knowledge of the patient's death. The Administrator stated that she was called to the patient's room and found that the patient was on the floor in front of her chair "like she just went down into her food." The Administrator stated that she was "still warm, had no pulse and was not breathing". The surveyor asked if she had any marks on her face? The Administrator said "maybe a superficial scratch, like rug burn." The surveyor asked her if there was any bleeding or blood on the floor? The Administrator stated "maybe a little blood from her nose." The surveyor asked the Administrator why the laceration was not documented in the patient record. The Administrator stated she wasn't aware that it was not documented.</p> <p>The patient record also failed to include evidence that the patient received any care on the morning</p>	H 304		

STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0318A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2009</b>
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H 304	<p>Continued From page 12</p> <p>of her death, including every 2 hour visual checks and meal preparation as outlined on the aide activity record and care plan.</p> <p>On 11/24/09, the surveyor interviewed the Director of Home Care regarding the patient's death. The Director stated that the patient had fallen face down and that she had a small "cut on her forehead, not edematous" The Director stated that she checked her mouth for food to see if she had choked there was no evidence that she choked. The surveyor asked the Director why she didn't document the laceration or "small cut" in the patient record? She stated she "just didn't" The surveyor asked the Director if there was blood on the floor, the Director stated that she didn't see any blood only food.</p> <p>The surveyor asked if the physician was notified of the laceration to the patient's forehead. The Director stated that she didn't remember but that the physician asked that the coroner be notified. The surveyor further questioned the Director about what the Coroner was told about the circumstances surrounding the patient's death including the fall and laceration. The Director stated that the Administrator talked to the coroner, but when the surveyor asked the same question again the Director stated she spoke to the coroner and only told him that the patient had a "medical collapse". The surveyor asked the Director how she knew that it was a "medical collapse" when the fall was unwitnessed? The Director stated "she had a medical collapse because her arms were not out and her legs were relaxed" when she was found. The surveyor asked for clarification regarding how she came to the conclusion that the patient died from a medical collapse. No further information was provided.</p>	H 304	<p><u>Correction</u></p> <p>A new policy/procedure has been developed to address HHA documentation of patient care on the personal care record. The HHA must document as care is provided and must have the personal care record reviewed by licensed staff at the end of each shift. The licensed staff will sign the bottom of the form indicating that the documentation is accurate and complete. The night HHA must have respective personal care records reviewed by the 7-3 licensed staff to verify appropriate and accurate documentation.</p> <p><u>Prevention of Reoccurrence</u></p> <p>Adherence to this policy will be monitored by reviewing HHA documentation sheets 3 times per week by Case Manager / Director of Home Care reported monthly at QA for 2 months, then reevaluate based on QA policy and procedure.</p> <p><u>Inservice</u></p> <p>HHA documentation policy was reviewed with all current staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new hires.</p>	<p><u>Responsible Party:</u> Administrator 12/30/09</p> <p><u>Responsible Party:</u> Director of Home Care &amp; Administrator 01/30/10</p> <p><u>Responsible Party:</u> Director of Home Care &amp; Administrator 01/12/10</p>

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	NAME OF PROVIDER OR SUPPLIER  MENORAH PARK HOME CARE AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 EAST GENESEE STREET SYRACUSE, NY 13214

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H 304	Continued From page 13.  3. Patient # 8 was admitted to the agency on 09/20/04 with a diagnosis of chronic obstructive pulmonary disease. The surveyor reviewed the patient record and noted that there was no documentation in the record after 10/04/09 from any home care staff. On 10/30/09 and 11/24/09, the surveyor interviewed the Director of Home Care and asked for any documentation after 10/04/09. The Director of Home Care stated that there was no subsequent documentation, that the patient died on 10/04/09. The surveyor asked for documentation of the patient's death including how she was found, who was notified and what the results were. The Director of Home Care stated that she is sure that she contacted the physician but that the patient was a hospice patient "so maybe the hospice called the doctor." As of 11/24/09, no further documentation was provided by the Director of Home Care.	H 304		
H 402	766.3(a) Plan of care  766.3 Plan of care.  The governing authority or operator shall ensure that:  (a) all patients are accepted for health care services only after a determination has been made by a registered professional nurse or by an individual directly supervised by a registered professional nurse that the patient's needs can be safely and adequately met by the agency. This Regulation is not met as evidenced by: Based on a review of 16 patient records, policy and procedures, and interviews with agency staff, there is a lack of evidence in 11 records that patients are accepted for care based on an assessment that the patient's needs can be	H 402	<i>1/29/10 accept. Full</i>  <u>Correction</u>  Pre-admission policy revision and procedural changes have been made to meet the requirements of 10NYCRR 766.3  <u>Protection of Others</u>  All new patients have been reviewed by an RN as to the new pre-admission assessment policy that assesses patients' needs can be safely and adequately met by the agency. This has been documented in the clinical records.	<u>Responsible Party:</u> Administrator 12/30/09  <u>Responsible Party:</u> Case Manager 01/15/10

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H 402	<p>Continued From page 14</p> <p>safely and adequately met by the agency. Patient # 1, 2, 3, 4, 6, 8, 11, 12, 13, 15, 16</p> <p>Failure of the agency to admit patients without an adequate assessment of their needs has the potential for negative outcomes.</p> <p>Specifically, the agency has admitted patients who require 24 hour supervision and who can not make their needs known, due to physical and/or cognitive reasons.</p> <p>1. Patient # 3 was admitted to the agency on 10/27/09 with a primary diagnosis of Alzheimer's disease and a surgical history of a colostomy. The initial nursing assessment completed on 10/27/09, failed to identify the complexity of the patient's care needs and failed to determine that the patient's needs can safely be met.</p> <p>The patient was admitted to a locked dementia unit. The assessment failed to address the following issues and identify how these needs could be safely met:</p> <ul style="list-style-type: none"> <li>- patient's cognitive ability to respond to questions. Specifically, the skilled nurse documented that the patient "could not respond to questions regarding hearing and vision due to her cognitive deficits." The skilled nurse failed to identify how the patient would make her needs known if she wasn't able to answer simple questions regarding her ability to see and hear.</li> <li>- complete assessment of the patient's dysphagia. The RN documented that the patient had dysphagia however, there is no assessment of the patient's ability to swallow pureed diet and how her nutritional needs would be met.</li> </ul>	H 402	<p><u>Prevention of Reoccurrence</u></p> <p>Adherence to this policy will be monitored by reviewing 100% of clinical records for all new admissions for January, February and March 2010, reported to QA monthly for compliance, trends and issues and then reevaluated based on QA policy and procedure.</p> <p><u>Inservice</u></p> <p>Pre-admission policy has been reviewed with all current professional staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new professional hires.</p> <p>Patient #3 sent to hospital on 11/15/09 then discharged home.</p>	<p><u>Responsible Party:</u> Case Manager 01/15/10</p> <p><u>Responsible Party:</u> Director of Home Care &amp; Administrator 01/12/10</p>

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1402	<p>Continued From page 15</p> <ul style="list-style-type: none"> <li>- assessment of the patient's ability to feed herself or how she would physically get her meals. During an observational visit on 10/30/09, the surveyor observed the patient being fed by a staff member. This was not part of the assessment or the plan of care.</li> <li>- assessment of patient's ability to transfer. The RN only documented that the patient had weakness, there was no assessment of difficulty transferring. The RN documented that the patient was dependent for all activities of daily living, but failed to document how these needs would be met.</li> <li>- assessment of the management of the patient's urinary incontinence.</li> </ul> <p>The registered nurse documented that the patient was totally dependent for all care needs however, there is no evidence that the patient can make her needs known, and no plan in place for the agency to provide frequent safety checks, patient positioning when in bed or to ensure that there are enough staff to assist the patient in exiting the building in the event of an emergency.</p> <p>On 11/24/09, the surveyors interviewed the Director of Home Care regarding the patient's extensive needs. The surveyor asked the Director of Home Care how she determined that the patient was appropriate for admission when she exceeded the agency criteria as outlined in the policy "Admission Criteria" dated February 2009. The policy states that the agency will not accept patients "who require 2 person transfer or is cognitively impaired to the degree which endangers the safety of the resident".</p>	H 402		

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H 402	<p>Continued From page 16</p> <p>The surveyor asked if the Director of Home Care was aware that the patient required feeding, 2 person transfer and so cognitively impaired that she couldn't speak? The Director of Home Care stated that the patient was only there on respite and was only going to be there a couple of months and that when she was at home she was "not that bad".</p> <p>2. Patient #15 was admitted to the agency on 07/15/09 with a diagnosis of type II diabetes and a corneal transplant. The initial nursing assessment failed to include an assessment of the patient's blindness, and ability to navigate new surroundings since admission to the agency. The skilled nurse failed to assess how the following needs will be met by the licensed agency:</p> <ul style="list-style-type: none"> <li>- ability to ambulate to meals or the bathroom related to her blindness</li> <li>- use of an assistive device including a cane.</li> <li>- patient requires assistance with activities of daily living</li> <li>- treatment and appropriate monitoring of dependent edema.</li> <li>- monitoring of diabetes including assessments of blood sugars</li> </ul> <p>This patient lives in an apartment which is located at the end of a long corridor. On 11/02/09, the surveyor was walking by the patient's open door and asked the patient how she called for help. The patient stated "I press my call button, but sometimes I can't find it so I have to wait for</p>	H 402	<p>Patient #15 transferred to Jewish Home of CNY on 01/03/10.</p>	

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H 402	<p>Continued From page 17</p> <p>someone to come and check on me". The surveyor asked if she has had to wait long, she stated "sometimes".</p> <p>3. Patient #2 was admitted to the agency on 12/18/08 with a primary diagnosis of Lou Gehrig's disease and secondary diagnoses of depression and anxiety. The patient is also receiving hospice services. The initial nursing assessment dated 12/18/08 failed to address the following patient needs:</p> <ul style="list-style-type: none"> <li>- patient safety: the RN documented that the patient had flaccid hand grip, foot drop, uses specialized wheel chair. There was no assessment of the patient's ability to transfer or how the patient would evacuate the building in the event of a fire.</li> <li>- patient's inability to swallow and potential for aspiration. The RN documented that the patient had dysphagia, however, there was no plan to observe for aspiration.</li> <li>- ability to communicate needs: the RN documented that the patient had slurred speech, however, failed to document the degree to which the slurred speech impaired his ability to call for help.</li> <li>- the patient has a progressive deteriorating neurological disease which will result in the patient's further inability to make his needs known</li> <li>- cardiovascular system - Although the RN documented that the patient had a "catheter to the left chest wall", there is no assessment of the condition of the insertion site, type of dressing, or the type of catheter in place. There is no evidence that the agency has a policy in place to</li> </ul>	H 402	<p>Patient #2 was transferred to the Jewish Home of CNY on 12/02/09.</p>	



NY State Department of Health

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402	Continued From page 18  maintain patency of the central venous catheter .  - respiratory system - The RN documented that the patient has dyspnea and an intermittent congested cough, uses bi-pap and "cough assistive device" The RN failed to assess the person responsible for assisting with the bi-pap machine, "cough assistive device" or the need for suctioning.  - endocrine status - there is no assessment of the patient's current diabetic status including monitoring blood sugars, yet he is taking a anti-diabetic medication.  - nutritional status including an assessment of the patient's inability feed self due to the flaccidity of the hands.  - genitourinary system - The skilled nurse states that the patient needs assistance with using a urinal however, there is no documentation of how this assistance will be provided.  On 10/26/09 the surveyor interviewed the RN case manager regarding the admission assessment. The case manager stated that he was not working for the agency at that time and didn't know what the patient looked like at that time.	H 402		
04	766.3(b) Plan of care  766.3 Plan of care.  The governing authority or operator shall ensure that:  ..... (b) a plan of care is established for each patient based on a professional assessment of the	H 404 <i>1/29/10 acc. JPN</i>	<u>Correction</u> New Plan of Care Policy and procedures developed to meet the requirements of 10NYCRR 766.3	Responsible Party: Administrator 12/30/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0318A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2009</b>
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**ENORAH PARK HOME CARE AGENCY****4101 EAST GENESEE STREET  
SYRACUSE, NY 13214**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
H 404	<p>Continued From page 19</p> <p>patient's needs and includes pertinent diagnosis, prognosis, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential.</p> <p>This Regulation is not met as evidenced by: Based on a review of 16 patient records, interviews with agency staff and policy and procedure reviews there is a lack of evidence in 16 records (100%) that the professional assessment is of sufficient scope to identify the needs of the patients.</p> <p>Failure to complete an adequate professional assessment has resulted in an inadequate plan of care and unmet patient needs.</p> <p>1. Patient # 11 admitted to the agency on 12/13/08 with a diagnosis of prostate cancer, a colostomy and depression. The patient currently resides on the locked dementia unit. The physician's plan of treatment states that skilled nursing assessments will be conducted every 3 months. The most recent skilled nursing assessment dated 09/11/09 failed to include the following:</p> <ul style="list-style-type: none"> <li>- complete respiratory assessment - the assessment includes an occasional cough however, there is no assessment of lung sounds</li> <li>- colostomy site, functionality and the person responsible for providing colostomy care.</li> <li>- bladder incontinence is noted however, there is no assessment of how incontinence is managed.</li> <li>- musculoskeletal assessment including the patient's mobility, use of a wheelchair, use of a trapeze for bed mobility</li> </ul>	H 404	<p><u>Protection of Others</u></p> <p>All present patients have had a new comprehensive assessment done, a new Plan of Care developed with input from patient/family and this is documented in the clinical record. All new patients will have a comprehensive assessment completed and a Plan of Care developed with input from patient/family with this documented in the clinical record.</p> <p><u>Prevention of Reoccurrence</u></p> <p>Adherence to this policy will be monitored by reviewing 100% of new admission's clinical records for January, February and March 2010, reported at QA monthly for compliance, trends and issues and then reevaluated based on QA policy and procedure.</p> <p><u>Inservice</u></p> <p>Plan of Care policy has been reviewed with all current professional staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new professional hires.</p>	<p><u>Responsible Party:</u> Case Manager 01/15/10</p> <p><u>Responsible Party:</u> Director of Home Care 01/15/10 &amp; ongoing</p> <p><u>Responsible Party:</u> Director of Home Care &amp; Administrator 01/12/10</p>

1/20/10 Acceptable Policy Implementation

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0318A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>ENORAH PARK HOME CARE AGENCY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4101 EAST GENESEE STREET SYRACUSE, NY 13214</b>	

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H 404	Continued From page 20  - a complete assessment of the patient's speech impairment. There is no assessment of the patient's ability to make needs known  - skin assessment - specifically, the RN documented that the patient had an open wound measuring 1.5 x 1.0 cm. The nurse failed to document the wound treatment provided. On 11/02/09, the surveyor interviewed the RN who assessed the wound and asked what wound care was ordered? The RN stated that the LPNs were placing DuoDerm on the wound and changing it every 3 days. There was no documentation in the clinical record that this wound treatment was provided, or that the wound was being monitored/measured.  - patient's ability to perform activities of daily living, the person responsible to provide this care.  On 10/30/09, at 07:30 am, the surveyor observed this patient in his wheel chair in the hallway outside of the common area on the "Dementia Unit" isolated from other patients. The surveyor attempted to communicate with the patient, the patient opened his eyes but did not speak. At 11:45 am, the surveyor again observed the patient sitting in his wheelchair in the same position in the hallway.  The Home Health Aide Patient Care Plan dated 05/07/09 failed to address how the above patient needs will be met.  2. Patient # 13 was admitted to the agency on 04/10/05 with a primary diagnosis of dementia, and secondary diagnoses of hypertension and depression. The patient resided on a locked	H 404	<u>Correction</u>  A new Skin Surveillance Policy has been developed to address skin assessments and wound treatment. HHA will complete a "skin sheet" with each bath and give to the nurse. Skin issues will be given to the Case Manager for follow-up with physician  <u>Protection of Others</u>  All patients on the agency roster as of 12/30/09 have had their most recent skilled nursing visit assessment re-done to ensure complete and accurate assessment. This is documented in the clinical record.  <u>Prevention of Reoccurrence</u>  Adherence to this policy will be monitored by reviewing 100% of current patients and all new admission's clinical records for January, February and March 2010, reported at QA monthly for compliance, trends and issues and then reevaluated based on QA policy and procedure.  <u>Inservice</u>  Skin Surveillance Policy has been reviewed with all current professional staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new professional hires.	<u>Responsible Party:</u> Administrator 01/15/10  <u>Responsible Party:</u> Director of Home Care 01/15/10  <u>Responsible Party:</u> Case Manager 01/15/10  <u>Responsible Party:</u> Director of Home Care & Administrator 01/12/10

1/29/10 acceptable Pauline Williams RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0318A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>ENORAH PARK HOME CARE AGENCY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4101 EAST GENESEE STREET SYRACUSE, NY 13214</b>	

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H 404	<p>Continued From page 21</p> <p>dementia unit. The physician's plan of care dated 04/13/09 to 10/13/09 included skilled nursing assessment visits every 3 months. The nursing assessment dated 09/28/09 failed to include an assessment of the following:</p> <ul style="list-style-type: none"> <li>- musculoskeletal status. Specifically, the RN documented on 09/28/09 that the patient was non-ambulatory and had unspecified weakness of the upper and lower extremities.</li> <li>- patient safety while in bed. The RN documented that the patient was non-ambulatory however, failed to assess the patient's bed mobility, use of half siderails including parameters for use and guidelines for patient supervision when in use. Specifically, the home health aide care plan dated 04/13/09 failed to include the use of side rails or the need for visual checks and/or repositioning while in bed. In fact the patient record failed to include the use of siderails at all. Surveyor interviews conducted with agency staff between 10/26/09 and 11/24/09 confirmed the patient's use of siderails.</li> </ul> <p>Additionally, the RN documented that the patient had a high potential for falls, however, the nurse failed to assess how the patient would be kept safe from falls.</p> <ul style="list-style-type: none"> <li>- cardiovascular system - there is no assessment of the patient's use of therapeutic anti-embolitic stockings (TED stockings), no assessment of peripheral pulses or edema. The RN documented cardiovascular "within normal limits".</li> <li>- neurosensory status including a description and assessment of the patient's tremors, speech, hearing and visual impairment. Specifically, the RN documented that the patient had tremors</li> </ul>	H 404	Patient # 13 expired on 10/03/09	

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LC0318A

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

C

12/17/2009

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ENORAH PARK HOME CARE AGENCY

4101 EAST GENESEE STREET  
SYRACUSE, NY 13214

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H 404	<p>Continued From page 22</p> <p>however, there was no assessment of the location of the tremors. Additionally, there was no assessment of severity of the patient's speech impairment and her ability to make her needs known.</p> <ul style="list-style-type: none"> <li>- nutritional status - there is no assessment of the patient's diet, nutritional intake or physical ability to self feed or an assessment of the patient's ability to chew and swallow food. Specifically, the plan of care dated 04/13/09 indicates that the patient's medications must be crushed, this was not assessed in the 09/28/09 assessment.</li> <li>- personal care needs assessment - there is no assessment of the patient's ability to perform own personal care and/or the person responsible to provide the care.</li> </ul> <p>3. Patient #2 was admitted to the agency on 12/08/08 with a primary diagnosis of Lou Gehrig's disease and secondary diagnoses of depression and anxiety and requires 24 hour skilled nursing care and supervision. The patient is also a hospice patient. The nursing assessment dated 09/30/09 failed to include an assessment the following:</p> <ul style="list-style-type: none"> <li>- patient safety: the RN documented that the patient had weakness, and a speech impairment. The RN failed to assess the severity of the patient's neuromuscular deficits. Specifically, on 10/26/09, the surveyor observed the patient sitting in his motorized wheelchair which he can control with the slight movement of the right hand between the thumb and forefinger. The surveyor also observed the patient attempting to verbally call for help. His voice was weak and the volume soft. The 09/30/09 assessment failed to include</li> </ul>	H 404	<p>Patient # 2 was transferred to the Jewish Home of CNY on 12/02/09.</p>	

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H 404	<p>Continued From page 23</p> <p>the above observations.</p> <ul style="list-style-type: none"> <li>- cardiovascular system - There was no assessment of the patient's Hickman catheter inserted into the right anterior chest wall that requires daily flushes. The RN failed to assess the patency of this vascular access device. There is also no assessment of the patient's pulse.</li> <li>- respiratory system - There was no assessment of the patient's lung sounds or the patient's ability to clear his own secretions. Additionally, the patient has Bi-PAP - respiratory support, ordered at night, there is no assessment of the patient's use this device.</li> <li>- digestive system - There was no assessment of the patient's bowel status including the last bowel movement.</li> <li>- nutritional status including an assessment of the patient's diet, food intake, the need to be fed all meals</li> <li>- genitourinary system - there was no assessment of the patient's urinary continence, use of timed voiding or use of a urinal.</li> </ul> <p>This record was reviewed with the RN case manager on 10/23/09, the surveyor asked the case manager to describe the patient's status. The case manager stated that the patient has very little movement, states that the patient can move his legs. The surveyor asked him to describe this movement, the case manager stated that he can flex his muscles in his legs a little. He stated that he has some trouble swallowing but can still eat moistened food. None of this description was included in the patient</p>	H 404		

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H 404	Continued From page 24 record.	H 404		
H 602	766.5(a) Clinical supervision  766.5 Clinical supervision. The governing authority shall ensure for all health care services that:  (a) sufficient numbers of appropriately trained and oriented supervisory staff are available to ensure the quality of patient care services provided by the agency. Such supervision shall include:  (1) ongoing review of cases and delegation of assignments by appropriate health care professionals;  (2) in-home visits to direct, demonstrate and evaluate the delivery of patient care;  (3) provision of clinical consultation; and  (4) professional consultation on agency policies and procedures. This Regulation is not met as evidenced by: Based on review of 16 patient records and 12 personnel records, policies and procedures, job descriptions for the RN Case Managers, staffing schedules and interviews with agency staff, there is no evidence in 16 of 16 patient records that the governing body employs sufficient numbers of appropriately trained and oriented supervisory staff to oversee the provision of patient care.  Failure to ensure adequate supervisory staff has resulted in a lack of patient's assessments, failure to provide adequate and safe patient care on evenings, and nights and the potential for unmet patient needs.	H 602	<p><u>Correction</u> Policies and procedures have been revised and developed to meet requirements of 10NYCRR 766.5 •Sufficient number of appropriately trained and oriented supervisory staff •On-going reviews of cases and delegation of assignments by appropriate professions •In-home visits to evaluate delivery of care •Professional consultation on agency policy and procedures •Staff adequately supervised •Evidence of adequate supervision •Appropriate delegation •Appropriate and complete documentation in clinical records •Plan of Care revised as needed •HHA supervised as appropriate by professional staff •Orientation of HHA to treatment with re- demonstration if needed •Instruction of aides as to the observations and written reports to be made</p> <p><u>Protection of Others</u> Staffing schedule has been and will be reviewed daily to ensure sufficient staffing to meet patient care needs identified on plans of care.</p> <p><u>Prevention of Reoccurrence</u> Adherence to 766.5 new On-call Supervision Policy and Procedures will be monitored for January, February and March 2010, reported monthly at QA to identify adherence to policy/procedure, compliance, trends and issues and reevaluated based on QA policy and procedure.</p> <p><u>Inservice</u> New policies have been reviewed with all current staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new hires.</p>	<p><u>Responsible Party</u> Director of Home C; &amp; Licensed Staff 01/26/10 &amp; ongoing</p> <p><u>Responsible Party</u> Director of Home C; ongoing</p> <p><u>Responsible Party</u> Case Manager / Director of Home C; 01/26/10 &amp; ongoing</p> <p><u>Responsible Party</u> Director of Home C; 01/12/10 &amp; ongoing</p> <p><u>Responsible Party</u> Case Manager 01/15/10</p> <p><u>Responsible Party</u> Director of Home C; &amp; Administrator 01/12/10</p>

1/9/10 acceptable for publication

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NAME OF PROVIDER OR SUPPLIER  HENORAH PARK HOME CARE AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 EAST GENESEE STREET SYRACUSE, NY 13214	

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H 602	<p>Continued From page 25.</p> <p>Specifically, the agency failed to:</p> <ul style="list-style-type: none"> <li>o ensure patient needs can be safely met when admitted to the agency See 766.3 (a)</li> <li>o ensure skilled nursing assessment are complete and plans of care are developed to meet those needs. See 766.3 (b)</li> <li>o ensure adequate staff are available on all shifts to implement plans of care See 766.5 (b)(1)</li> <li>o ensure services are provided in accordance with agency policies, especially with respect to advance directives and patient's found unresponsive. See 766.2 (a)(1)</li> <li>o ensure that the agency employs RN supervisory staff who are readily accessible on all shifts to evaluate patient condition and safety.</li> <li>o ensure that agency staff have the ability to call 911 in an emergency situation. Specifically, the phone system is internal and agency staff does have the capability to call outside the facility to reach a home care Supervisor after hours or for emergency medical services.</li> </ul> <p>The agency employs a Director of Home Care and 2 RN case managers who are responsible for patient assessments and supervision of home health aides as outlined in the Job Description for "Case Manager/RN". However, the Director of Home Care and 2 RN case managers are only scheduled on the day shift.</p> <p>On 10/26/09, the surveyor interviewed the Director of Home Care and asked how staff contacted the agency's on-call system during the</p>	H 602		



## New York State Department of Health

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H 602	<p>Continued From page 26</p> <p>evening and night shift. The Director of Home Care stated that staff call the nursing office in the attached Skilled Nursing Facility (SNF) who would come and assess the patient's needs. This procedure is in direct contradiction to the agency policy dated 05/03 labeled "24 hour On-Call Clinical and Professional Consultation." This policy states "An agency RN will be available to both the client and staff 24 hours per day, 7 days per week" There is no mention of the RN being an employee of the SNF. Furthermore, this policy cannot be followed due to the disabled phone system for outside calls.</p> <p>The surveyors interviewed the Director of Home Care on 11/24/09 and again asked about how the on-call system worked for the home care agency. The Director of Home Care stated that the on call coverage is provided by the Supervisor in the attached "skilled nursing facility because they are here and it just makes sense." The Director of Home Care stated that there is also a home care nurse on call during the week and on the weekend that the SNF Supervisor can call if needed. The Director of Home Care stated that she is on call Monday through Friday and the RN case managers cover the weekends. The Director of Home Care provided the surveyor with an on-call log for the weekends, the documentation in the log was minimal, and there was no record of on-call communication during the week.</p> <p>The surveyor asked the Director of Home Care where calls go for aides/nurses calling in sick? She stated that the person would call into the SNF office and the SNF supervisor would take care of finding coverage.</p> <p>Home health aide staff were interviewed</p>	H 602		

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H 602	Continued From page 27  throughout the survey from 10/26/09 to 11/10/09. A home health aide who primarily cares for patients on the third floor evenings was interviewed. The surveyor asked the aide to explain what her procedure is if she found that a patient had fallen out of bed and needed emergency care. The aide stated that she has "had to leave the patient on the floor, run down a long corridor to find a licensed practical nurse or find a phone in the common area to call the nursing office in the attached SNF." The surveyor asked approximately how long it takes for the Supervisor to assess the patient. The home health aide states that some times it is quick but, it could take a long time for a Supervisor from the SNF to assess the patient and call 911 for emergency treatment.  On 11/06/09, the surveyor interviewed a Supervising Nurse employed by the skilled nursing facility weekend evenings. The surveyor asked if she was oriented to home care policies and procedures. She stated that she knew of them because she worked with the current Director of Home Care, but she had no formal orientation to home care and has had no current home care inservice.  The Supervising Nurse from the SNF also stated that she receives calls from the staff in an emergent situation including patient death. The Supervising Nurse stated that she is responsible for pronouncing death if a patient should die during her shift.	H 602		
614	766.5(b)(1) Clinical supervision  766.5 Clinical supervision. The governing authority shall ensure for all health care services that:	H 614	<u>Correction</u>  New policy/procedure has been developed to meet the requirements of 10NYCRR 766.5.  •Staff to provide services at times and frequencies specified in Plan of Care	Responsible Party: Administrator 12/30/09

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H 614	Continued From page 28  ..... (b) all staff delivering care in patient homes are adequately supervised. The department shall consider the following factors as evidence of adequate supervision:  (1) staff regularly provide services at the times and frequencies specified in the patient's plan of care and in accordance with the policies and procedures of their respective services. This Regulation is not met as evidenced by: Based on a review of 16 patient records, and interviews with the Director of Home Care and the Director of Human Resources, evidence is lacking in 16 patient records (100%) that the agency staff provides care at the times and frequencies specified in the plan of care. Patients #1-16  Failure of the agency to provide care as specified in the patient plan of care may lead to unmet patient needs and possible negative patient outcomes.  Specifically:  1. Patient # 13 was admitted to the agency on 4/10/05 with a diagnosis of dementia. The Home Health Aide care plan dated 4/13/09 states the patient needs assistance on each shift with partial bath with AM and PM care, shower every Tuesday and Saturday evening, dressing, transfers, ambulation, and feeding. The nursing assessment dated 09/28/09 states that the patient was non-ambulatory, had unspecified weakness of the upper and lower extremities, required medications crushed for swallowing difficulties, and that the patient had tremors.  Surveyor interviews with staff were completed	H 614	<u>Protection of Others</u>  All current patients personal care records (aide activity record) are reviewed on each shift by a licensed staff to ensure staff provides services at the times and frequencies specified in the patient's Plan of Care and in accordance with the policies and procedures of the respective services.  <u>Prevention of Reoccurrence</u>  Adherence to new policy/procedure will be monitored 3 times per week, reported monthly at QA to monitor compliance, trends and issues, then reevaluated based on QA policy and procedure.  <u>Inservice</u>  New policy has been reviewed with all current staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new professional hires.	<u>Responsible Party:</u> Case Manager 01/15/10  <u>Responsible Party:</u> Director of Home Care 01/15/10 & ongoing  <u>Responsible Party:</u> Director of Home Care & Administrator 01/09/10

Yes - acceptable Policy will be done

New York State Department of Health

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**ENORAH PARK HOME CARE AGENCY****4101 EAST GENESEE STREET  
SYRACUSE, NY 13214**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
H 614	<p>Continued From page 29</p> <p>between 10/26/09 and 11/24/09 with staff who were summoned to the patient's room when she was found dead, entangled in the siderails of her bed at 10:30 pm.</p> <p>The aide activity record for the evening shift dated 10/03/09 was reviewed and failed to include evidence that any care was provided during the evening prior to her death. The aide activity record was blank for toileting every 2 hours and visual checks every 2 hours.</p> <p>Aide Activity Records for August and September 2009 (Day, Evening, and Night shifts) were reviewed, there is no evidence that care was provided in accordance with the aide care plan as follows:</p> <ul style="list-style-type: none"> <li>- Toileting not provided every 2 hours around the clock: <ul style="list-style-type: none"> <li>o 14 out of 61 day shifts</li> <li>o 45 out of 61 evening shifts</li> <li>o 8 out of 61 night shifts</li> </ul> </li> <li>- Visual checks every 2 hours around the clock: <ul style="list-style-type: none"> <li>o 14 out of 61 day shifts</li> <li>o 45 out of 61 evening shifts</li> <li>o 8 out of 61 night shifts</li> </ul> </li> <li>- Showers not provided Tuesdays and Saturday evenings: <ul style="list-style-type: none"> <li>o 18 out of 18 evenings</li> </ul> </li> <li>- Dressing assistance not provided: <ul style="list-style-type: none"> <li>o 42 out of 61 day shifts</li> </ul> </li> </ul>	H 614		

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0318A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORAH PARK HOME CARE AGENCY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4101 EAST GENESEE STREET SYRACUSE, NY 13214</b>	

4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 614	<p>Continued From page 30</p> <ul style="list-style-type: none"> <li>o 18 out of 61 evening shifts</li> <li>- Assistance with transfers not provided: <ul style="list-style-type: none"> <li>o 35 out of 61 day shifts.</li> <li>o 52 evenings out of 61 evenings</li> </ul> </li> <li>- Ambulation assistance not provided: <ul style="list-style-type: none"> <li>o 61 out of 61 day shifts</li> <li>o 36 out of 61 evenings</li> </ul> </li> <li>- Feeding assistance not provided during each meal: <ul style="list-style-type: none"> <li>o 14 out of 61 day shifts.</li> <li>o 60 out of 61 evening shifts.</li> </ul> </li> </ul> <p>The surveyor interviewed the Director of Home Care on 10/26/09. No new information was provided.</p> <p>2. Patient #2 was admitted to the agency on 12/18/08 with a diagnosis of ALS (Lou Gehrig Disease). The patient requires total care and is dependent on staff for all of his personal care, positioning, feeding and transferring needs.</p> <p>The Home Health Aide care plan dated 07/02/09 states the patient is to receive AM and PM assistance 7 day a week for partial bath, mouth care on each shift, shave daily, getting dressed, and transfer assistance of 2 people with a mechanical lift to his electric wheel chair.</p> <p>The aide care plan failed to include repositioning this patient while in bed.</p> <p>Aide Activity Records for August (Day, Evening, and Night shifts) and September 2009 (Day and</p>	H 614	<p>Patient #2 was transferred to the Jewish Home of CNY on 12/02/09.</p>	

New York State Department of Health

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**ENORAH PARK HOME CARE AGENCY**

**4101 EAST GENESEE STREET  
SYRACUSE, NY 13214**

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H 614	<p>Continued From page 31</p> <p>Evening Shifts) were reviewed, there is no evidence that care was provided in accordance with the aide care plan as follows:</p> <p>* The agency failed to produce documentation of any care provided during the night shift for the month of September. This information was requested by the surveyor from the Director of Home Care on 10/26 and again 12/03/09. No document was provided.</p> <ul style="list-style-type: none"> <li>- visual check not provided every 2 hours around the clock <ul style="list-style-type: none"> <li>o 5 out of 61 day shifts.</li> <li>o 34 out of 61 evening shifts</li> <li>o 17 out of 31 night shifts for August only.</li> </ul> </li> <li>- toileting assistance not provided every 2 hours around the <ul style="list-style-type: none"> <li>o 5 out of 61 day shifts.</li> <li>o 38 out of 61 evening shifts</li> <li>o 17 out of 31 night shifts for August only.</li> </ul> </li> <li>- partial bath not provided with am and pm care <ul style="list-style-type: none"> <li>o 34 out of 61 day shifts.</li> <li>o 20 out of 61 evening shifts</li> </ul> </li> <li>- mouth care not provided with am and pm care <ul style="list-style-type: none"> <li>o 31 out of 61 day shifts</li> <li>o 61 out of 61 evening shifts</li> </ul> </li> <li>- shaving the patient not provided daily <ul style="list-style-type: none"> <li>o 34 out of 61 day shifts</li> </ul> </li> </ul>	H 614		

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

LC0318A

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

C

12/17/2009

NAME OF PROVIDER OR SUPPLIER

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4101 EAST GENESEE STREET  
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H 614	<p>Continued From page 32</p> <ul style="list-style-type: none"> <li>- getting the patient dressed was not provided each shift               <ul style="list-style-type: none"> <li>o 19 out of 61 day shifts</li> <li>o 30 out of 61 evening shifts</li> <li>o 31 out of 31 night shifts for the month of August.</li> </ul> </li> <li>- transfers out of bed with the use of a mechanical lift and 2 aide assistance not provided on each shift               <ul style="list-style-type: none"> <li>o 32 out of 61 day shifts</li> <li>o 46 out of 61 evening shifts</li> <li>o 30 out of 31 night shifts for the month of August</li> </ul> </li> </ul> <p>The surveyor interviewed the Director of Home Care on 10/26/09. No new information was provided.</p> <p>3. Patient # 16 was admitted to the agency on 3/21/06 with diagnoses of Diabetes and Dementia. The patient's Home Health Aide care plan states the patient is to receive assistance with showers 2-times a week, (no specific days), shampoo with showers, mouth once a shift, and Boost (no amount given), once a shift.</p> <p>Aide Activity Records for September and October 2009 (Day, Evening, and Night shifts) were reviewed, there is no evidence that care was provided in accordance with the aide care plan as follows:</p> <ul style="list-style-type: none"> <li>- showers and shampoo were not provided 2 times a week. In fact there is no evidence that the patient received a shower or shampoo at all</li> </ul>	H 614	<p>Patient #16 was transferred to the hospital on 11/30/09.</p>	

New York State Department of Health

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NAME OF PROVIDER OR SUPPLIER

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**MEMORAH PARK HOME CARE AGENCY****4101 EAST GENESEE STREET  
SYRACUSE, NY 13214**

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H 614	Continued From page 33 during the months of September and October.  - toileting not provided every 2 hours around the clock  o 23 out of 61 day shifts o 52 out of 61 evening shifts o 13 out of 61 night shifts  - visual checks not provided every 2 hours o 23 out of 61 day shifts o 53 out of 61 evening shifts o 12 out of 61 night shifts  The surveyor interviewed the Director of Home Care on 11/2/09. No new information was provided.	H 614		
11002	766.9(a) Governing authority  Section 766.9 Governing authority.  The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall:  (a) be responsible for the management and operation of the agency;  (b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations. This Regulation is not met as evidenced by: Based on a review of the agency's Annual Statistical Reports and an interview with the staff from the department of health, there is no evidence that the agency submitted the required 2005, 2006, and 2007 Annual Statistical Reports.	H1002	<i>12/10 acceptable</i> <u>Correction</u> New policy has been developed to meet requirements of 10-NYCRR 766.9 <u>Protection of Others</u> Annual statistical reports will be submitted for 2005, 2006, 2007. It is the responsibility of the Director of Home Care to submit the annual statistical report upon the request of NYSDOH. The Director of Finance for Menorah Park will provide the financial information. <u>Prevention of Reoccurrence</u> Adherence to this reporting requirement will be monitored and reported annually at QA, date depending on when report can be transmitted. <u>Inservice</u> New policy has been reviewed with all current professional staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new professional hires.	<u>Responsible Party:</u> Administrator 12/30/09  <u>Responsible Party:</u> Director of Home Care 1/12/10 & ongoing  <u>Responsible Party:</u> Administrator & ongoing  <u>Responsible Party:</u> Director of Home Care & Administrator 01/09/10



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H1002	Continued From page 34  Failure of the Governing Body to ensure that the agency complies with all Federal, State and local regulations and laws may lead to unmet patient needs and possible negative patient outcomes.	H1002		
H1006	766.9(c) Governing authority  Section 766.9 Governing authority.  The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall:  ..... (c) ensure the development of a written emergency plan which is current and includes procedures to be followed to assure health care needs of patients continue to be met in emergencies that interfere with delivery of services, and orientation of all employees to their responsibilities in carrying out such a plan. This Regulation is not met as evidenced by: Based on a review of the agency's emergency preparedness plan and an interview with the agency's Director of Home Care, evidence is lacking that the agency has established an emergency preparedness plan that includes all critical elements as required by the New York State Department of Health Dear Administrator Letter dated May 10, 2005.  Specifically evidence is lacking for the following:  1. That the current patient roster includes the identification of patient's dependent on electricity and the ability to vacate the building with or without assistance.  2. That the agency has collaborated with community partners in emergency preparedness planning and that the agency has participated in	H1006  <i>100% acceptable</i>	<p><u>Correction</u></p> <p>New Emergency Procedure Manual/Triage Book has been developed to meet requirements of 10NYCRR 766.9c and DAL dated May 10, 2005</p> <p><u>Prevention of Reoccurrence</u></p> <p>Adherence to this Triage Book requirement will be monitored in January, February and March 2010, reported annually at QA, then reevaluated based on QA policy and procedure.</p> <p><u>Inservice</u></p> <p>Emergency Procedure Manual has been reviewed with all current staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation of new hires.</p> <p>Triage Book and policy has been reviewed with all professional staff and a signed staff roster of this inservice has been placed on file in the Director of Home Care's office and is available for DOH review.</p>	<p><u>Responsible Party:</u> Director of Emergency Planning /Maintenance 12/30/09</p> <p><u>Responsible Party:</u> Director of Emergency Planning /Maintenance 12/30/09</p> <p><u>Responsible Party:</u> Director of Home Care &amp; Administrator 01/19/10</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0318A</b>	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2009</b>
		A. BUILDING _____ B. WING _____	

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SYRACUSE, NY 13214**

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H1006	Continued From page 35  disaster drills and exercises.  3. That the agency has policies and procedure addressing: - how the patient roster and staff call down list are kept current. - how the patient roster and staff call down list are to be used in an emergency. - response for information from community partners in an emergency. - annual review and update of the plan. - review of plan with staff at orientation and annually.  Failure of the agency to establish an emergency plan may lead to unmet patient needs and possible negative patient outcomes.  The surveyor interviewed the Director of Home Care on 10/26/09 and 11/02/09. The Director of Home Care stated that the agency does not have an emergency plan and that they would follow the skilled nursing facility emergency plan. The Surveyor reviewed the skilled nursing facility emergency plan. The plan does not address the significant number of physically and cognitively complex patients served by the Licensed Home Care Services Agency.	H1006		
1014	766.9(g) Governing authority  Section 766.9 Governing authority.  The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall:  (g) employ or contract for a sufficient number of staff to coordinate, direct and deliver services to patients accepted for care in accordance with	H1014	<p><i>12/10/09 acceptable</i></p> <p><u>Correction</u> Policies and procedures have been developed to meet the requirements of 10NYCRR 766.9(g) •Sufficient number of staff •Employ qualified RN •Accept and retain only those persons whose health care needs can be safely and adequately met by Menorah Park Home Care</p> <p><u>Protection of Others</u> Daily staffing levels are matched to patient care needs as identified in their Plans of Care.</p>	<p><u>Responsible Party:</u> Administrator 12/30/09</p> <p><u>Responsible Party:</u> Director of Home Care ongoing</p>

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H1014	<p>Continued From page 36</p> <p>prevailing standards of professional practice. This Regulation is not met as evidenced by: Based on a review of the agency staffing and an interview with the Director of Home Care evidence is lacking that the agency employs enough staff to adequately provide services to patients as required by the patient's plans of care and standards of professional practice.</p> <p>Failure of the agency to provide services as required may lead to unmet patient needs and possible negative patient outcomes.</p> <p>Currently the agency serves 50 patients with complex needs, many of whom are compromised both physically and mentally, and who live on residential units in an "institutional-like" environment.</p> <p>Patients reside on any one of the following four distinct units that are located on the 2nd and 3rd floors of a 3 story building and are separated by long corridors: a locked dementia unit (21 current patients); a palliative care unit (5 current patients) for end of life care; and 2 independent units which house the other 24 patients. Congregate dining areas are located on each unit except Palliative Care.</p> <p>The patient's needs identified in the skilled nursing assessments are beyond the availability of agency staff, and the units are configured in such a manner that precludes staff from communicating with one another and assisting with one another.</p> <p>Specifically, the staff are assigned to specific units as identified on the staff assignment sheets for 10/30/09 - 11/15/09. The staffing for the Locked Dementia Unit on the 2nd Floor which</p>	H1014	<p><i>1/29/10 acceptable</i></p> <p><u>Prevention of Reoccurrence</u></p> <p>Adherence to this policy will be monitored by reviewing staffing schedule for January, February and March 2010 to ensure staffing is adequate to meet the needs of the patients' plans of care, reported monthly at QA, then reevaluated based on QA policy and procedure.</p> <p><u>Inservice</u></p> <p>This policy has been reviewed with all current professional staff. A signed staff roster has been placed in our files and is available for DOH review.</p> <p>This information will be incorporated into orientation for new professional hires.</p>	<p>Responsible Party: Director of Home Care 01/15/10</p> <p>Responsible Party: Director of Home Care and Administrator 01/15/10</p>

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H1014	<p>Continued From page 37</p> <p>serves 21 patient's is as follows:</p> <p>Days</p> <p>1 LPN 2 HHA</p> <p>Evenings</p> <p>1 LPN 2 HHA</p> <p>Nights</p> <p>2 HHA</p> <p>Please note that the one LPN scheduled was responsible for medication administration and treatments for all patients with the exception of those patients on the Palliative Care Unit.</p> <p>The agency serves 21 patients who reside on a locked dementia unit on the 2nd floor. Each patient requires 24 hour supervision and direction for all activities of daily living including; toileting; bathing; and medication administration. All of these patients have moderate to severe forms of dementia which render them incapable of making decisions, a number of these patient's also have physical disabilities requiring the assistance of 2 people for cares.</p> <p>There is no evidence that there is enough staff to ensure that patients can be evacuated in the event of an emergency or to ensure that all patients that require physical assistance with personal care are having their needs met.</p> <p>Additionally, there is no evidence that home health aides can contact RN supervisory staff in a</p>	H1014		

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NAME OF PROVIDER OR SUPPLIER  <b>ENORAH PARK HOME CARE AGENCY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4101 EAST GENESEE STREET SYRACUSE, NY 13214</b>	

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H1014	Continued From page 38  timely manner for assistance in the event of an emergency on evenings and nights. RN supervision is provided by staff of the attached Skilled Nursing Facility, which results in delays of assessments when there is a change in the patient's condition. Additionally, there is no mechanism for staff to call 911 in an emergency situation. Specifically, the Operator has disabled the phones from calling outside the Facility (SNF) and the only way for staff to contact a Supervisor is to call the nursing office in the Skilled Nursing Facility. If the staff leave a message, the number is relayed to a beeper carried by the Supervising Nurse in the SNF.  This was reviewed with the Administrator on 11/10/09. No further information was provided.	H1014		
H1036	766.9(l) Governing authority  Section 766.9 Governing authority.  The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall:  ..... (l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided. The committee shall meet at least four times a year to:  (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption;  (2) conduct a clinical record review of the safety,	H1036	<u>Correction</u>  Policies and procedures have been developed to meet the requirements of 10NYCRR 766.9(l).  Monthly QA meeting with set agenda. Director of Home Care will summarize findings citing trends, issues and improvement strategies to Medical/Dental Advisory Committee quarterly. Minutes of Medical/Dental Advisory Committee are forwarded to Board for review and action.  All policies and procedures are reviewed annually by QA/Board. Monthly 10% of policies are presented at QA for review with date of review indicated on policy.  <u>Responsible Party:</u> Director of Home Care ongoing	

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H1036	Continued From page 39  adequacy, type and quality of services provided which includes:  (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and  (ii) all cases with identified patient complaints as specified in subdivision (j) of this section;  (3) prepare and submit a written summary of review findings to the governing authority for necessary action; and  (4) assist the agency in maintaining liaison with other health care providers in the community. This Regulation is not met as evidenced by: Based on a review of the agency's Quality Improvement Committee minutes and Governing Body meeting minutes for the most recent 12 months and an interview with the agency's Director of Home Care, evidence is lacking that the Quality Improvement Committee oversees the agency's standards of care.  Specifically, the Quality Improvement meeting minutes failed to include the following significant components:  - There is no evidence the Quality Improvement Committee reviews the agency's policies and makes recommendations for changes as needed.  - That at each meeting the agency's Quality Improvement Committee makes a random selection of current patient records and discharged patient records for the last 3 months, for a review of quality of services, including safety and adequacy.	H1036	<i>12/10 acceptable Randomly selected</i>  <u>Prevention of Reoccurrence</u> Adherence to the policy/procedure will be demonstrated through the use of a set format for minutes, data finding, clinical record review, policy reviews, admissions and discharges and complaints. Meeting dates have been set for the coming year and distributed to QA members and written quarterly summaries of findings will be prepared and forwarded to the governing board. Random clinical record review will be peer completed according to tracking sheet and presented at QA for identification of trends, issues and opportunities to improve.  3 clinical records will be randomly selected and will be a discharged patient.  <u>Responsible Party:</u> Director of Home Care and Administrator 01/15/10 & ongoing	

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(4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
11036	Continued From page 40  - That the results of the record reviews are used to track issues and that trending of these issues is discussed and recommendations are made to resolve these issues.  - That patient complaints are addressed and resolved.  - That the agency's Quality Improvement Committee prepares and submits a written summary of the review of policies and patient record reviews to the Governing Body for necessary review and action by the Governing Authority.  - That the Quality Improvement Committee maintains a liaison with other community health providers.  Further review of the Governing Body meeting minutes included the exact information from the Quality Improvement Committee, and lacked an action plan to address the items listed above.  Failure of the agency's Governing Authority to ensure that the agency's Quality Improvement Committee oversee's the agency's standards of care may lead to unmet patient needs and possible negative patient outcomes.  The surveyor interviewed the Director of Home Care on 11/02/09. No new evidence was provided.	H1036		
1142	766.9(o) Governing Authority  Section 766.9 Governing authority  (o) Health Provider Network Access and	H1142	<u>Correction</u>  Policies and procedures have been developed to meet the requirements of 10NYCRR 766.9(o)	Responsible Party: Administrator 12/30/09

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

LC0318A

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY  
COMPLETED

C

12/17/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ENORAH PARK HOME CARE AGENCY

4101 EAST GENESEE STREET  
SYRACUSE, NY 13214

(4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
H1142	<p>Continued From page 41</p> <p>Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department's Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency's HPN coverage consistent with the agency's hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency's HPN accounts shall consist of, but not be limited to, the following:</p> <p>(1) sufficient designation of the agency's HPN coordinator(s) to allow for HPN individual user application;</p> <p>(2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health;</p> <p>(3) adherence to the requirements of the HPN user contract; and</p> <p>(4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis.</p> <p>This Regulation is not met as evidenced by: Based on an 10/20/09 on-line review of the</p>	H1142	<p>Director of Finance is the Directory Coordinator for Home Care</p> <p>The present Director of Home Care listed on HPN</p> <p><u>Prevention of Reoccurrence</u></p> <p>Adherence to this policy will be monitored for January, February and March 2010, reported monthly at QA via the set format of the minutes/agenda, then reevaluated based on QA policy and procedure.</p> <p><u>Inservice</u></p> <p>HPN Policy has been reviewed with all current professional staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new professional hires.</p>	<p>Responsible Party: Director of Finance 01/12/10</p> <p>Responsible Party: Director of Home Care 10/12/10</p> <p>Responsible Party: Director of Finance ongoing</p>



STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0318A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2009</b>
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**ENORAH PARK HOME CARE AGENCY****4101 EAST GENESEE STREET  
SYRACUSE, NY 13214**

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11142	Continued From page 42  agency's Health Provider Network account and an interview with the agency Director of Home Care evidence is lacking for the following:  1. That the agency has assigned a HPN 24 hour, seven day a week contact.  2. That the account is kept current.  - the account lists a former employee as the agency Director, Emergency Response Coordinator, HPN Coordinator and HPN Security Coordinator  3. That the agency has policies relating to the HPN.  Failure of the agency to establish a HPN account that is current and complete may lead to unmet patient needs and possible negative patient outcomes.  The surveyor interviewed the Director of Home Care on 10/30/09. No new evidence was provided.	H1142		
1306	766.11(c) Personnel  766.11 Personnel.  The governing authority or operator shall ensure for all health care personnel:  (c) that the health status of all new personnel is assessed and documented prior to assuming patient care duties. The assessment shall be of sufficient scope that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of	H1306 <i>Deficiency</i> <i>10/10 accepted</i>	<u>Correction</u> Policies and procedures were developed to meet the requirements of 10NYCRR 766.11(c)  <u>Protection of Others</u> All present employees have had their personnel records reviewed and the records are compliant with requirement 10NYCRR 766.11(c)	<u>Responsible Party:</u> Director of Human Resources 12/30/09  <u>Responsible Party:</u> Director of Human Resources 12/30/09

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0318A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ENORAH PARK HOME CARE AGENCY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4101 EAST GENESEE STREET SYRACUSE, NY 13214</b>
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H1306	Continued From page 43  his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. This Regulation is not met as evidenced by: Based on a review of 13 employee records and interviews with the Director of Home Care and the Director of Human Resources, there is no evidence in 4 records that the health status of each employee is assessed and documented before the employee begins patient care. Employees: # E6, E8, E11, E12  Specifically: The health records for employees # E6, E8, E11, and E12 lack an initial physical by a physician to ensure that each employee is free of any health impairments which might put patients at risk.  Failure of the agency to ensure that employees receive a physical and are free of any health impairment before starting care of patients, may lead to unmet patient needs and possible negative patient outcomes.  The surveyor reviewed this information with the Director of Home Care and the Director of Human Resources on 11/3/09. No new information was provided.	H1306	<u>Prevention of Reoccurrence</u> All new hires will have the personnel record reviewed for adherence to requirement 10NYCRR 766.11(c).  <u>Inservice</u> Policy has been reviewed with all Human Resources staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new hires in Human Resources.  <u>Correction</u> Policies and procedures have been developed to meet the requirements of 10NYCRR 766.11(d)(2)  <u>Protection of Others</u> All present employees' records have been reviewed to ensure they meet the requirements of 10NYCRR 766.11(d)(2)	<u>Responsible Party:</u> Director of Human Resources 12/30/09  <u>Responsible Party:</u> Director of Human Resources 12/30/09  <u>Responsible Party:</u> Director of Human Resources 12/30/09
H1318	766.11(d)(2) Personnel  766.11 Personnel.  The governing authority or operator shall ensure for all health care personnel:  (d) that a record of the following tests, examinations or other required documentation is maintained for all personnel who have direct	H1318		

*1/29/10 acceptable M. Williams*

AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
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H1318	<p>Continued From page 44</p> <p>patient contact:</p> <p>.....</p> <p>(2) a certificate of immunization against measles for all personnel born on or after January 1, 1957, which means:</p> <p>(i) a document prepared by a physician, physician assistant, specialist assistant, nurse practitioner, licensed midwife or a laboratory possessing a laboratory permit issued pursuant to Part 58 of this Title, demonstrating serologic evidence of measles antibodies; or</p> <p>(ii) a document indicating two doses of live virus measles vaccine were administered with the first dose administered on or after the age of 12 months and the second dose administered more than 30 days after the first dose but after 15 months of age showing the product administered and the date of administration, and prepared by the health practitioner who administered the immunization; or</p> <p>(iii) a document indicating a diagnosis of the person as having had measles disease prepared by the physician, physician assistant, specialist assistant, licensed midwife or nurse practitioner who diagnosed the person's measles; or</p> <p>(iv) a copy of the document described in subparagraph (i), (ii), or (iii) of this paragraph which comes from a previous employer or the school which the person attended as a student. This Regulation is not met as evidenced by: Based on a review of 13 employee records and interviews with the Director of Home Care and Director of Human Resources, there is no evidence in 4 records that the employees had proper certification of immunization against measles [rubeola] before beginning patient care.</p>	H1318	<p><i>1/29/10 accr m</i></p> <p><u>Inservice</u> Policy has been reviewed with all Human Resources staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new hires in Human Resources.</p> <p><u>Responsible Party:</u> Director of Human Resources 12/30/09</p>	

STATEMENT OF DEFICIENCIES  
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H1318	Continued From page 45  Employees: #E1, E9, E10, E11  Specifically: The health records for employees # E1, E9, E10, and E11 lack documentation that each employee received administration of 2 doses of live measles vaccine or serological evidence of measles antibodies.  Failure of the agency to ensure that employees have received proper immunizations may put patients at risk and possible negative patient outcomes.  The surveyor reviewed this information with the Director of Home Care and the Director of Human Resources on 11/3/09. No new information was provided.	H1318		
H1330	766.11(d)(4) Personnel  766.11 Personnel.  The governing authority or operator shall ensure for all health care personnel:  (d) that a record of the following tests, examinations or other required documentation is maintained for all personnel who have direct patient contact:  (4) ppd (Mantoux) skin test for tuberculosis prior to assuming patient care duties and no less than every year thereafter for negative findings. Positive findings shall require appropriate clinical follow up but no repeat skin test. The agency shall develop and implement policies regarding follow up of positive test results. This Regulation is not met as evidenced by: Based on a review of 13 employee records and interviews with the Director of Home Care and	H1330	<u>Correction</u> Policies and procedures have been developed to meet the requirement of 10NYCRR 766.11(d)(4)  <u>Protection of Others</u> All present employees' personnel files are compliant with the requirements of 10NYCRR 766.11(d)(4).  <u>Prevention of Reoccurrence</u> All new hires personnel records will be monitored for January, February and March 2010 for compliance to 10NYCRR 766.11(d)(4), then every 3rd new hire's personnel record will be monitored for one year and reported monthly at QA.	<u>Responsible Party:</u> Director of Human Resources 12/30/09  <u>Responsible Party:</u> Director of Human Resources 12/30/09  <u>Responsible Party:</u> Director of Human Resources 12/30/09 & ongoing

100% acceptable findings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>LC0318A</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2009</b>
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11330	Continued From page 46  the Director of Human Resources, there is no evidence in 2 records that the employees had yearly skin testing for tuberculosis. Employees: # E4, E6  Failure of the agency to ensure that employees receive annual tuberculosis testing may put patients at risk and possible negative patient outcomes.  The surveyor reviewed this information with the Director of Home Care and the Director of Human Resources on 11/3/09. No new information was provided.	H1330	<u>Inservice</u> Policy has been reviewed with all Human Resources staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new hires in Human Resources.  <u>Correction</u> New policies and procedures have been developed to meet the requirements of 10NYCRR 766.11(e) <u>Protection of Others</u> All present employees' personnel files have been reviewed to ensure compliance with 10NYCRR 766.11(e). <u>Prevention of Reoccurrence</u> All new hires personnel records will be monitored for January, February and March 2010 for compliance to 10NYCRR 766.11(d)(4), then every 3rd new hire's personnel record will be monitored for one year and reported monthly at QA.	<u>Responsible Party:</u> Director of Human Resources 12/30/09  <u>Responsible Party:</u> Director of Human Resources 12/30/09  <u>Responsible Party:</u> Director of Human Resources 12/30/09
11334	766.11(e) Personnel  766.11 Personnel.  The governing authority or operator shall ensure for all health care personnel:  ..... (e) that personal identification is produced by each applicant and verified by the agency prior to retention of an applicant by the agency. This Regulation is not met as evidenced by: Based on a review of 13 employee records for professional and para professional employees and an interviews with the Director of Home Care and the Director of Human Resources, 9 records lacked evidence of verification of employee identification. Employee's # E1, E3, E4, E6, E8, E9, E10, E11, E12  Specifically:  - Six employee personnel records lack a date of hire on the US Department of Justice I-9 Form. Employee # E4, E6, E8, E10, E11, E12.	H1334	<u>Inservice</u> Policy has been reviewed with all Human Resources staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new hires Human Resources.  <u>Responsible Party:</u> Director of Human Resources 12/30/09 & ongoing  <u>Responsible Party:</u> Director of Human Resources 12/30/09	<u>Responsible Party:</u> Director of Human Resources 12/30/09 & ongoing  <u>Responsible Party:</u> Director of Human Resources 12/30/09

12/17/09 acceptable

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H1334	Continued From page 47  - One employee record lacked the required birth date on the US Department of Justice I-9 Form. Employee # E1.  - One employee record contained the wrong form of identification to verify citizenship on the US Department of Justice I-9 Form. Employee #E3  - One employee record did not contain a US Department of Justice I-9 Form. Employee #E9.  Failure to verify employee identification may lead to unmet patient needs and possible negative patient outcomes.  The records were reviewed with the Director of Home Care and the Director of Human Resources on 11/3/09. No further evidence was provided.	H1334		
H1336	766.11(f)(i) Personnel  766.11 Personnel.  The governing authority or operator shall ensure for all health care personnel:  (f) (i) that prior to patient contact, employment history from previous employers, if applicable, and recommendations from other persons unrelated to the applicant if not previously employed, are verified.  This Regulation is not met as evidenced by: Based on a review of 5 Home Health Aide records and an interviews with the Director of	H1336	<u>Correction</u> Policies and procedures have been developed to meet the requirements of 10NYCRR 766.11(f)(i) <u>Protection of Others</u> All present employees' employment files have been reviewed and are in compliance with 10NYCRR 766.11(f)(i) <u>Prevention of Reoccurrence</u> Monitoring of all new hires' personnel records for January, February and March 2010 for compliance with 10NYCRR 766.119(f)(i) and reported at QA then every 3 <sup>rd</sup> new hire personnel record will be monitored for 1 year then reevaluated.	<u>Responsible Party:</u> Director of Human Resources 12/30/09  <u>Responsible Party:</u> Director of Human Resources 12/30/09  <u>Responsible Party:</u> Director of Human Resources 12/30/09 & ongoing

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H1336	Continued From page 48  Home Care and Director of Human Resources, 5 records (100%) lacked evidence of verification of employment history. Employee's # E1, E4, E8, E10, E12  The Home Health Aide records did not contain documentation of 3 employment history references as required by 1991 Onondaga County Local Law # 4.  Specifically: 1. Employee records for # E1, E8, E10, E12 each contained 2 references.  2. Employee record for # E4 contained no references.  Failure to verify employee employment history may lead to unmet patient needs and possible negative patient outcomes.  The records were reviewed with the Director of Home Care and the Director of Human Resources on 11/3/09. No further evidence was provided.	H1336	<u>Inservice</u> Policy has been reviewed with all Human Resources staff. A signed staff roster has been placed in our files and is available for DOH review. This information will be incorporated into orientation for new hires in Human Resources.  <u>Correction</u> Policies and procedures have been developed to meet the requirements of 10NYCRR 766.11(i)  <u>Protection of Others</u> All present employees have met the requirements of 10NYCRR 766.11(i) and have received 12 hours of inservice. The Director of Home Care has received her job description and 10NYCRR 766 regulations. There is a memo regarding her appointment to her position in her personnel file.	<u>Responsible Party:</u> Director of Human Resources 12/30/09
I1342	766.11(i) Personnel  766.11 Personnel.  The governing authority or operator shall ensure for all health care personnel:  (i) that all personnel receive orientation to the policies and procedures of the home care services agency operation and in-service education necessary to perform his/her responsibilities. At a minimum:  (1) home health aides must participate in 12	H1342		<u>Responsible Party:</u> Director of Human Resources 12/30/09

FORM APPRO

## New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  LC0318A	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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H1342	<p>Continued From page 49</p> <p>hours of in-service education per year; and</p> <p>(2) personal care aides must participate in six hours of in-service education per year.</p> <p>This Regulation is not met as evidenced by: Based on a review of 13 personnel records for professional and paraprofessional personnel records, and interviews with the Director of Home Care and the Director of Human Resources, there is no evidence in 13 records (100%) that agency staff received orientation to home care. Employees 1 - 13.</p> <p>Additionally, 5 Home Health Aide records lacked evidence that each aide received 12 hours of in-service education each year.</p> <p>Employee's # E1, E4, E8, E10, E12</p> <p>Specifically:</p> <p>Each personnel record contained documentation that the staff received an orientation manual, there is no specifics stating that the orientation is for home care or for the attached Skilled Nursing Facility. Additionally, on 12/03/09, the surveyor interviewed the Director of Home Care and reviewed her personnel record. The surveyor asked the Director of Home Care if she was oriented to home care. The Director stated that she was oriented by the former Director of Home Care. The Director of Home Care stated that when she was appointed to her current position, she was verbally informed of her duties by the RN Administrator and did not receive anything in writing. The surveyor asked the Director of Home Care if she received a written Job Description. She stated no.</p> <p>Furthermore, the personnel record for the Director failed to include documentation of her</p>	H1342	<p><i>Inservice</i></p> <p>Policy has been reviewed with all Human Resources staff. A signed staff roster has been placed in our files and is available for DOH review.</p> <p>This information will be incorporated into orientation for new hires in Human Resources.</p> <p><i>Responsible Party:</i> Director of Human Resources 12/30/09</p> <p><i>11/29/10 acceptable</i></p> <p>Personnel record for the Director of Home Care includes documentation of orientation to job description, review of the DOH Regulations for licensed home care agencies and has been assigned Administrator role, HPN Directory changed.</p> <p>• Search has begun for Administrator / Director of Patient Services who has licensed home care experience. <i>Responsible Party:</i> Director of Home Care 01/22/10 &amp; ongoing</p> <p>Director of Home Care / Administrator positions have been combined. Director of Home Care / Administrator reports to CEO. 01/27/10</p> <p>Job description for Administrator of Home Care developed. Presently advertising for position. 01/29/10 &amp; ongoing</p>	



**12/17/2009**

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STATEMENT OF DEFICIENCIES  
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DATE

H1342

Continued From page 50

appointment to her position, orientation to the  
position or a Job Description.Additionally, a review of the personnel records  
failed to include documentation that home health  
aides receive 12 hours of education each year.Failure of the agency to provide Home Health  
Aides with 12 hours of inservice a year may lead  
to unmet patient needs and possible negative  
patient outcomes.The records were reviewed with the Director of  
Home Care and the Director of Human  
Resources on 11/3/09. No further evidence was  
provided.

H1342

Contacted a NYAHS Consultant  
Activities included:

- Off-site review of written Plan of  
Correction
- On-site observational rounds with  
suggestions for improvement
- Presence at regional office of DOH  
to discuss Plan of Correction

Responsible P  
CEO 12/31/0  
ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/19/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>337212</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/19/2007</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VNS ITHACA TOMPKINS CO CHHA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>138 CECIL A MALONE DRIVE</b> <b>ITHACA, NY 14850</b>
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G 000	<p><b>INITIAL COMMENTS</b></p> <p>The following statement of deficiencies represents the results of a full recertification survey and an on site investigation of 2 complaints, # NY00048827 and NY00045947.</p> <p>A post certification survey of the agency's Certified Home Health Agency (CHHA) was commenced October 12. The post certification survey was initiated as a follow-up survey to the recertification survey completed on January 24, 2007, event N3Q412.</p> <p>On October 17, 2007 it was determined that none of the citations identified on the January 24, 2007 survey had been corrected, and additional deficiencies were identified. The survey was converted to a standard level recertification survey on October 17, 2007, and an additional 17 clinical records were reviewed, and an additional 4 home visits were made. As a result of the standard level survey, and the complaint investigation, systemic problems with skilled nursing were identified, and resulted in an extended level survey on November 06, 2007.</p> <p>After further investigation, deficient practices were identified at condition level in the following 6 Conditions of Participation: Patient Rights, Organization, Services, and Administration; Plan of Care; Skilled Nursing Services; Clinical Records; and Evaluation of the Agency's Program.</p> <p>During the survey, a total of 15 clinical records were reviewed (1-15) for the recertification survey with 5 observational home visits. An additional 7 (16-22) clinical records were reviewed as part of complaint investigation #NY00045947.</p>	G 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Mary E. Harrington</i>	TITLE  <i>Interim Executive Director</i>	(X6) DATE  <i>1/2/08</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 100	Additionally reviewed during the survey were the agency's: policy and procedure manual; Professional Advisory Committee, and Governing Body, meeting minutes for the most recent twelve months; Quality Assurance program; complaint investigation log; on-call log; contracts; emergency disaster plan, and 16 personnel records. Interviews were conducted with: the Agency Administrator, Director of Nursing, Agency Consultant, and agency staff. <b>484.10 PATIENT RIGHTS</b>	G 100	<b>G100 PATIENT RIGHTS</b>  The DPS and or Designee will implement <b>revised</b> PATIENT RIGHTS policies and procedures by <b>1/15/08</b> with sufficient detail to ensure that agency staff promote and protect all patient rights. A focus will be directed at patient participation in care planning development and changes prior to implementation and ensuring that patients receive access to services provided through Medicare and Medicaid.	1/15/08
G 109	This <b>CONDITION</b> is not met as evidenced by: The agency failed to protect and promote the rights of all patients. Specifically, the agency failed to include patients in developing their plan of care, and failed to ensure patient's rights to access services provided through medicare and medicaid. See G 109  The cumulative effect of these systemic problems resulted in the home care agency's failure to ensure the provision of quality health care. Additionally, this failure to promote patient's rights in negative outcomes for patients # 8,13. <b>484.10(c)(2) RIGHT TO BE INFORMED AND PARTICIPATE</b>  The patient has the right to participate in the planning of the care.  The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.  This <b>STANDARD</b> is not met as evidenced by:	G 109	<b>G109 RIGHT TO BE INFORMED AND PARTICIPATE</b>  The DPS and/or Designee will review and or revise where appropriate policies and procedures related to protecting and promoting patient rights by <b>01/08/08</b> . The DPS and or AA will present the revised policies and procedures to the Professional Advisory Committee (PAC) by <b>01/09/08</b> for review and approval and to the Governing Authority for review and approval by <b>01/10/08</b> .	1/08/08 1/09/08 1/10/08

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G 109	<p>Continued From page 2</p> <p>Based on a review of 22 clinical records, 5 observational home visits, and interviews with the Agency Administrator (AA) and the Director of Nursing (DON), evidence is lacking in 2 records the agency is adequately including patients in developing their plan of care, and ensuring patients rights to access services provided through Medicare and Medicaid. Patients # 8, 13</p> <p>Failure to include the patient in developing their plan of care, and failure to support patients in accessing Medicare and Medicaid services, has resulted in a negative outcome for patients # 8 and 13, and has the potential for agency wide unmet patient needs, and possible negative patient outcomes.</p> <p>Evidence is as follows:</p> <p>1. HV</p> <p>Patient #8 is a [REDACTED] alert and oriented wheelchair bound male who was admitted to the CHHA/LTHHCP on 11/16/04. He has lived alone since January 2007 and is diagnosed with: Metabolic Bone Disease; End Stage Renal Failure; Benign Hypertension; and two Decubitus Ulcers on his buttocks (one stage 4 and one unstageable), requiring daily dressings. He also has excoriated skin on both lower legs, feet, and toes, requiring daily wound care. He receives hemodialysis three times a week.</p> <p>The Agency has failed repeatedly to include this patient in decisions involving his care, as evidenced by: clinical record review; interviews with the patient, the patient's mother, the Administrator, the DPS, and the skilled nurse case manager; and investigation of complaint #NY00048827.</p>	G 109	<p>The DPS met with staff on 12/20/07 to provide an overview of the Statement of Deficiencies issued by DOH to the agency on 12/19/07, and at this time patient rights were discussed and reviewed. Another review of patient rights with staff is planned prior to implementation of the revised policies and procedures by 1/15/08.</p> <p>Policy and procedure revisions will include, but not be limited to the following:</p> <ul style="list-style-type: none"> <li>• Discussion with patient and or caregiver prior to the start of care and ongoing encouraging participation in care planning and treatment</li> <li>• Accurate initial and ongoing assessment of patient and or caregiver willingness and ability to participate in the care plan</li> <li>• Identification of responsibilities that the patient and or caregiver has agreed to assume and assessment of teaching needs with a final assessment by the nurse prior to implementation of the plan that the patient and or caregiver are competent in the area of responsibility.</li> <li>• Documentation in the case conference section of the patient medical record by the case manager at the start of care and ongoing related to changes that reflects patient or caregiver participation in care planning, an understanding of his or her responsibilities in the care and agreement</li> </ul>	<p>12/20/07</p> <p>1/15/08</p>

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G 109	<p>Continued From page 3</p> <p>Specifically:</p> <p>Prior to January 2007, the patient was able to transfer independently from wheelchair to bed and to toilet with a slide board. On 1/18/07, the VNS skilled nurse (SN) case manager documented that he received a phone call from the dialysis unit stating that the patient has an open area on his "butt". however the dialysis unit was unable to visualize the wound to assess it. Evidence is lacking that:</p> <ul style="list-style-type: none"> <li>- the SN had been visiting the patient 1-2 times per month per the plan of care. Specifically, the SN failed to visit from 11/02/06 - 12/28/06.</li> <li>- the SN assessed the patient's skin integrity when visits were made</li> <li>- skin breakdown had been reported to the SN by the aides who were bathing the patient 3 times per week per the plan of care.</li> <li>- the SN visited the patient until 02/02/07, which was 2 weeks after receiving the phone call from the dialysis unit.</li> </ul> <p>On 02/02/07 the SN documented about the patient " his mother has been able to change the dressings daily this week ....he feels he may need more aide hours ". The SN documented: " #1 R. buttocks: 4cm x 5cm x 1.0cm deep ...bloody wound bed. Surrounding area excoriated and tender to touch; #2 to R side of coccyx 4cm x 2cm skin tear; #3 left buttocks 6cm x 4.5cm ...skin tender and excoriated as well. " Although the SN documented she would visit weekly for</p>	G 109	<ul style="list-style-type: none"> <li>• Revision in Patient Satisfaction Survey to clearly solicit patient or caregiver perception related to participation in care planning</li> <li>• Ensuring access to payment sources such as Medicare and Medicaid</li> </ul> <p><b>Patient #8</b> is still on service and as documented in this report, following the DOH staff visit to the patient's home on <b>11/08/07</b> a discussion with agency staff resulted in implementation of an appropriate care plan. The patient agreed to receive shift nursing at night during which time wound care and transfers are performed. The above plan continues. Although patient #8 does not appear under other standards in this report, the deficiencies identified under the Patient Rights section are identified in other patients and are addressed in the Plan of Correction.</p> <p><b>Patient #13</b> is no longer on service; however areas of concern are to be addressed in policy and procedure revisions</p> <p><b>Evaluation of promotion and protection of patient rights on a concurrent basis:</b></p> <p>The DPS and or Designee will assess compliance with the above on a concurrent basis through start of care, restart of care, and recertification and</p>	<p>1/15/08</p> <p>1/15/08</p> <p>1/15/08</p>

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G 109	<p>Continued From page 4</p> <p>wound assessments, evidence is lacking that the patient's request for additional HHA services were addressed, or the SN discussed a plan for wound care with the patient, including the agency's role and responsibilities.</p> <p>On 02/07/07, the SN documented the mother called the SN at home at 5:45 PM, reporting that the patient's wounds appeared reddened and sore and left buttock had greenish fibers. The SN documented: (the SN) " suggested that she take the patient to the ER for a good wound evaluation because there isn't anything this nurse can do in the patient's home ". The SN failed to:</p> <ul style="list-style-type: none"> <li>- make a home visit</li> <li>- evaluate the effectiveness of the current plan of treatment</li> <li>- discuss the mother's ability to continue to perform wound care daily</li> <li>- discuss with the patient the need for additional services and adaptive equipment.</li> </ul> <p>On 2/16/07, the supervising nurse documented the presence of 2 stage 3 pressure ulcers on bilateral buttocks, requiring daily dressing changes. The patient's lower legs were also excoriated, " mother doing dressing change [daily] ...will go to doctor for [evaluation of wound] ". Evidence is lacking the supervising nurse: reviewed the care plan; evaluated the need for additional services; addressed the patient's request for additional HHA services</p> <p>On 02/26/07, the supervising nurse documented she discussed with the SN case manager "</p>	G 109	<p>case management audits and case conferences by <b>01/15/08</b> (see G143)</p> <p><b>Evaluation of promotion and protection of patient rights on a retrospective basis is incorporated into the 2 to 4 week record review process, the quarterly clinical record review process, and Patient Satisfaction Survey (see G250).</b></p>	<p>1/15/08</p> <p>1/15/08</p>

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G 109	<p>Continued From page 5</p> <p>problem with mother being overwhelmed with care needs and requiring more frequent SN ....possible increase aide frequency to alleviate mother of that need and set up [wound care clinic] for Wednesday, RN for Tuesday and Thursday, and mother M,F,S,Sun ". There is no evidence that either the patient or patient ' s mother were involved or given a choice in the development of this plan.</p> <p>On 3/21/07, the Supervising Nurse documented " concerns re: healing, possibility of infection from stool ...needs hospital bed with air mattress ". Up until 3/21/07, the patient was on a transplant list for a new kidney. He was removed from the list due to the status of the multiple wounds.</p> <p>On March 22, 2007 the SN documented " He is motivated to have great improvements in his wound status .... He needs to pursue air mattress on his bed and a different wheelchair that allows him to recline for pressure relief ....discussed with patient our concerns about his living by himself and not being able to transfer himself ....he currently has an aide who can wash him from his waist up. ...if he is incontinent of stool, he has been lying or sitting in it until skilled nurse or mom comes for next dressing change ...SN explored the patient ' s feelings re: nursing home placement even short term ...explained benefits of having nursing staff available for wound care when needed and prompt care of bowel incontinence ....Patient is adamantly against nursing home placement. He feels he has fought hard for his independence. He wants to keep the time he has to visit with his children in his home. "</p> <p>There was no evidence the VNS made an attempt to work with the patient to develop a plan</p>	G 109		



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G 109	<p>Continued From page 6</p> <p>that would provide: sufficient home care services to support the patient in his home; emotional and physical support for the patient and the patient's mother, who was providing the bulk of his care; and a plan for repositioning to facilitate wound healing. Documentation in the record reinforces the fact that the patient consistently voiced his desire to remain in his home, and his motivation to work towards that goal is well documented. However, the VNS neglected to identify his needs and work cooperatively with him in an attempt to achieve his goal. Instead, the VNS continued to advocate for and propose nursing home placement, knowing it was inconsistent with the patient's wants and needs.</p> <p>On 04/02/07, 05/16/07, and 06/22/07 the SN and supervising nurse documented through phone calls to the physician and patient care meetings the patient had numerous and serious unmet needs in the home. Specifically, the patient: was unable to transfer out of the wheelchair, sometimes for 18 hours at a time; was often incontinent of stool; had slow healing of stage 3 and stage 4 ulcers; was isolated and unable to toilet himself; had not had a shower in months; needed to have 2 nurses or an aide present to assist nurse each day; was at high risk for infection and needs to have more aggressive care for decubiti.</p> <p>Additionally, the SN and supervising nurse repeatedly documented the patient was adamant in wanting to remain at home and was agreeable to get all equipment needed, but there was a delay.</p> <p>Despite the patient's adamant statements indicating he wished to remain at home, the</p>	G 109		

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G 109	<p>Continued From page 7 agency failed to:</p> <ul style="list-style-type: none"> <li>- document why the patient had not been included in the 05/16/07 patient care conference</li> <li>- consider the patient ' s choice. Specifically, the agency continued to advocate for nursing home placement</li> <li>- consult with the patient to develop a plan that would meet his needs and provide him with not only the opportunity, but the support to make decisions regarding his own care</li> <li>- develop a plan to provide additional services to meet the patients needs, promote his right to participate in the planning of his care, and support the patient ' s ultimate goal to remain at home</li> <li>- ensure immediate intervention to address the patient ' s unmet safety needs</li> </ul> <p>On 06/22/07, althoughh the agency had identified and documented a risk for injury of their staff in physically providing care for the patient, the agency failed to identify the patient ' s mother/family was equally at risk, and documented " we will ask parents to provide wound care on Tuesday and Thursday (mother already doing M, Fri., Sat., Sun care) ...spoke with mother - asked her if she can perform dressing change until equipment is avail "</p> <p>On 6/25/07, the supervising nurse documented: All caregivers, MD, supervisors ....have been informed SN visits on hold until further notice except for aide supervision " . The supervising nurse documented a phone call to the wound care clinic nurse " ....need for higher level of care</p>	G 109		

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G 109	<p>Continued From page 8</p> <p>that we can ' t provide enough services in home for his safely and caregivers safety still waiting on equipment to be approved " .</p> <p>Despite VNS ' acknowledgement that the patient was motivated to stay at home, the VNS relinquished their responsibilities to provide care. The agency failed to work diligently with the patient to develop a safe plan to meet his needs. There was no evidence the agency worked with the patient. Instead, the agency withdrew services from the patient, thereby decreasing his chances for healing and increasing his safety risks. Additional nursing responsibilities were assigned to the mother, who was already overwhelmed. VNS failed to provide support to the patient ' s mother who was working full time and trying to care for her ailing son.</p> <p>The VNS Administrator notified the Department of Health on 6/26/07 of the agency ' s decision to discontinue wound care for the patient: " We can continue to provide nursing assessments, but not wound care ...I wanted to explain the situation in case mom calls to complain " . In response, DOH directed the Administrator on 6/27/07 to continue wound care and to procure the necessary equipment immediately.</p> <p>On 6/28/07, the patient received a hospital bed and hoyer lift. The agency resumed skilled nursing visits twice per week to perform dressing changes on the buttock wounds.</p> <p>Nursing notes dated 7/3/07, 7/5/07, 7/10/07, 7/12/07, 7/17/07, and 7/19/07 all contain a statement " no safety hazards " . However, the progress notes stated the patient was chair bound, required assistance of one to transfer, and</p>	G 109			

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G 109	<p>Continued From page 9</p> <p>required a wheelchair. The Home Assessment Abstract, the assessment tool used for the LTHHCP, which was completed by the VNS supervising nurse and dated 8/9/07, stated: " Mother does care to buttocks and feet on M, F, S, Su, SN does care on T/TH ....if in bed is unable to leave home in case of emergency ....[continues] to try to find someone to help put him into bed in evening ....[frequently] spends all night in his wheelchair which causes increased pressure on buttock decubiti ". The assessment tool stated that the Home Health Aide was assigned five days a week for two hours each visit. However, based on documentation in the clinical record and interview with the patient, HHA services were provided only two to three days per week.</p> <p>Despite the patient ' s requests for needed services, there is no evidence the agency discussed this plan with the patient and attempted to secure additional services to meet his needs.</p> <p>On October 1, 2007, the agency received a complaint that the agency was discharging the patient from the LTHHCP. The agency documented that they responded to the to the complainant that the patient would be transferred to the CHHA and would received skilled nursing services from the CHHA. VNS informed the patient of this plan rather than give him an opportunity to participate in the plan. This plan would result in termination of the Medical Social Worker. There is no indication that the patient participated in this decision or that he was given an opportunity to voice his point of view</p> <p>In a memorandum to the local Department of Social Services, dated 10/05/07, the Administrator documented: " In regard to the</p>	G 109		

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G 109	<p>Continued From page 10</p> <p>waivered service, our Quality Assurance consultant and Licensed Social Worker on our Professional Advisory Committee have determined that the social work services received in the long term program are not justified as revealed by the lack of progress in these sessions "</p> <p>This statement is in direct contradiction to the MSW summary documented on the recertification plan of treatment (HCFA 485) dated 9/2/07 until 10/31/07: " Pt. is cooperative with treatment plan. He has done well with parenting over the summer. Still coping with frustration of his situation. " The Social Worker documented in the patient ' s record on 10/23/07: " met with Pt. He is concerned with the possible change of program. He does not want to lose Long Term Care Program. Wants to continue to get all the services the program provides. He vented his frustrations about the current situation. He seemed very concerned and angry at the situation. "</p> <p>On 11/08/07 a home visit was conducted by the surveyor. During the visit, the patient informed the surveyor that he wanted to remain in the LTHHCP. He said he did not want to lose the Social Work service because it is helpful. He said if he had to go without it he could, but he didn ' t want to go without it or have to start with someone new.</p> <p>The patient further explained that he has been attempting to receive more services. He stated that he does not want to be a burden to his parents. His parents leave their home every Monday, Wednesday, and Friday at 5 am and drive to the patient ' s home, and transport him to</p>	G 109		

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G 109	<p>Continued From page 11</p> <p>dialysis. His parents then go to work. After dialysis he goes to the wound care center for dressing changes and takes a van home. He doesn't arrive back home until around 2:30 PM. He stated that he would prefer to have his dressing changed at home, but he was directed by the agency to go to the wound center on dialysis days. He receives aide services only on Monday and Friday at about 3 PM. He has asked for an aide in the evening who can put him in bed around 9 PM, because he doesn't want to go to bed at 5 PM. He informed the surveyor he was told there were not enough aides. He said, as a result, he stays in his wheelchair all night.</p> <p>The patient informed the surveyor that he was told by the DSS caseworker that he would approve additional services if the agency informed him of the services needed. Although the SN documented on 05/16/07 " DSS will look at budget to see what we can afford ", evidence is lacking the SN followed up with the DSS regarding additional services.</p> <p>In addition to the agency failing to: promote the patient's right to participate in the planning of his care; support the patient's ultimate goal to remain at home; and ensure immediate intervention for unmet safety needs; the agency also failed to understand their role for care coordination and case management.</p> <p>It was not until the Department of Health directed the agency to work collaboratively with the patient and the Department of Social Services, that an appropriate plan was developed and implemented to meet the patient's needs. The revised plan of care includes: shift nursing care during the night shift, enabling the patient to transfer to bed; and</p>	G 109		

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G 109	<p>Continued From page 12</p> <p>medical social work services. The shift nurse also provides prescribed wound care, which provides relief for the patient ' s mother.</p> <p>2. Patient #13 was admitted to the agency on 09/07/07 with a primary diagnosis of left lower leg ulceration. The plan of care included daily dressing changes by the Skilled Nurse (SN). Evidence is lacking that the SN considered the patient/family's reluctance and inability to perform the dressing changes, supported by the physician's reluctance to decrease the SN visits, in developing the plan of care. The SN persisted in developing a plan that required the family to perform the daily dressing changes. Specifically:</p> <p>On 09/12/07 The SN documented communicating the following with the RN team leader: "due to the chronic nature of the patient's wounds, copious wound drainage, and simple dressing change, the patient was not qualifying for continued daily visits from an RN". The SN faxed the above findings to the physician, and requested the patient be seen by the wound care center so that the patient could be discharged from home care. The SN also inquired as to whether the patient could drive himself. Evidence is lacking that the SN:</p> <ul style="list-style-type: none"> <li>- discussed the plan to discontinue daily dressing changes by the SN with the patient, or that the patient was in agreement with the plan to drive to the wound care center for the dressing changes</li> <li>- identified that a dressing change involveing 8 step dressing was not a simple dressing</li> <li>- identified the patient's wounds were not stable since admission to the agency only 5 days prior, due to copious drainage.</li> <li>- considered the patient may not be able to physically drive himself to the wound care center.</li> </ul>	G 109		

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G 109	<p>Continued From page 13</p> <p>On 09/13/07 and 09/14/07 the SN documented that the physician ordered the patient should not drive, and the SN should continue daily dressing changes due to the constant drainage, and that the patient could not drive.</p> <p>On 09/17/07 and 09/24/07 the SN had re faxed the request she had made to the physician which specified the patient was a candidate for the wound care center, and the agency would like to discharge the patient, the fax also included a conflicting statement indicating the SN could see the patient one time per week for assessment.</p> <p>On 09/25/07 the SN documented she had sent the patient to the emergency room because the patient's leg was covered with maggots. The wound was cleansed, and the patient was given one dose of IV cephalexin (antibiotic) and sent home. The patient was to continue antibiotics by mouth at home.</p> <p>The physician signed the conflicting orders on 09/27/07.</p> <p>On 09/28/07 the SN documented she had explained to the patient that Medicare will not pay for daily visits with a chronic non healing wound, and she had the patient sign the "paperwork". The SN left a message for the daughter that starting 10/01/07 either she or her brother will need to learn the wound care. Evidence is lacking that the SN included the patient, or the patient's children in developing the plan to make the children responsible for their father's wound care.</p> <p>Additionally, the SN attempted to obstruct the</p>	G 109		



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G 109	<p>Continued From page 14</p> <p>patient's access to Medicare services by advising the patient and the physician that the daily wound care could not be provided through Medicare, despite the deteriorating wound status and complicated dressing change.</p> <p>On 09/30/07 the SN documented she had stated to the patient the dressing change needed to be taught to his son or daughter. The patient stated he was not sure they would do it for him, as they never had in the past. Evidence is lacking the patient was in agreement with the change in the plan to decrease the SN visits.</p> <p>On 10/01/07 the SN documented teaching the son to perform the dressing, and he was to perform the dressing change on 10/02/07. Evidence is lacking the patient was in agreement with his son being made responsible for the dressing changes.</p> <p>On 10/05/07 the SN obtained a physician order to decrease the SN visits to one time per week for wound assessment and dressing change, and that the son and daughter are willing to perform the daily dressing changes. Evidence is lacking, however, that the patient's daughter was willing to perform the daily dressing changes.</p> <p>On 10/12/07 the SN visited the patient, and documented the patient was not clear as to the status of the agency's home visits. The SN reminded him he had signed a document indicating the agency believed the services being provided will no longer be covered by medicare (HHBN - Home Health Advance Beneficiary Notice), that the SN would visit 1-2 times per week, that the daily dressings would be stopped, and that the son and daughter would be helping.</p>	G 109		

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G 109	<p>Continued From page 15</p> <p>The patient then stated he must have misunderstood. Evidence is lacking that:</p> <ul style="list-style-type: none"> <li>- the patient was in agreement with the plan for his son to perform the daily dressing changes</li> <li>- the daughter was taught how to perform the dressing changes, or was willing to assist in dressing changes</li> <li>- the SN identified the patient may have been confused about the plan of care because the SN had faxed multiple requests to the physician which indicated the agency would like to discharge the patient, as well as the SN could continue weekly visits for assessment.</li> </ul> <p>Despite the family being unable or unwilling to assist in dressing changes, and the physician's reluctance to make the family responsible, the SN persisted in developing a plan which made the family responsible for the patient's daily dressing changes. Specifically, on 10/15/07 the SN documented:</p> <ul style="list-style-type: none"> <li>- a phone call to the daughter indicating the daughter stated she could not get to the patient's home easily until 8:00 PM to do the dressing changes as she worked. The SN also documented on 10/15/07, the daughter had stated to the son she was not willing to assist with the dressing changes because "the wounds were hard to look at, and she did not have the stomach for it".</li> <li>- the physician had recommended to the family that they see if another agency would do the dressing changes, as this agency would not.</li> <li>- the son stated he did not mind the wound care, and agreed to SN visits 1 - 2 times per week, however, had made several subsequent phone</li> </ul>	G 109		

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G 109	Continued From page 16 calls to the SN, and advised her he would not be able to perform dressing changes on 10/16/07, 10/17/07, 10/18/07, 10/22/07, 10/23/07, 10/25/07 or 10/26/07.  This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.	G 109	<b>G122 ORGANIZATION, SERVICES &amp; ADMINISTRATION</b>  The Agency Administrator (AA) and Director of Patient Services (DPS) met with the Governing Authority on <del>01/31/08</del> to discuss the draft Plan of Correction developed to address deficiencies identified as a result of the DOH statement of deficiencies issued pursuant to a survey completed at the Visiting Nurse Service of Ithaca on 12/19/07. The draft Plan of Correction was approved as presented including the resources required to implement the plan.	12/31/07
G 122	<b>484.14 ORGANIZATION, SERVICES &amp; ADMINISTRATION</b>  This CONDITION is not met as evidenced by: o Failure of the governing body to assume responsibility for the overall management of the agency. G128  o Failure to ensure all patient rights are protected and promoted. G109  o Failure to develop and implement a system which ensures that significant patient symptoms are identified; that priority needs are addressed, and immediately reported to the physician. G164, G172  o Failure to implement a system which ensures: that initial nursing assessments are complete and accurate; plans of care are individualized and provide specific interventions to meet patient's needs; the written plans of care are being followed; physicians are consulted in the development and modification of the plan of care; changes in patients condition are readily identified and physicians are promptly notified; documentation of reassessment visits are complete and reflect the patient's current status;	G 122	AA, DPS, or Designee will revise and intensify the agency's quality improvement program and to review and revise as appropriate all other policies and procedures identified in the POC by 1/08/08, with overall policy and procedure and administrative review by 3/01/08.  The Governing Authority agreed with the recommendation by the AA and DPS that until further notice no new patients should be admitted to the agency, unless under special circumstances as approved by the AA and DPS. The agency will open to admissions only after the agency has come back into full compliance with the Conditions of Participation and the AA and DPS report that the agency had made acceptable progress in correcting quality of care issues.	1/08/08 3/01/08

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G 122	<p>Continued From page 17</p> <p>and quality care is provided to each patient. G 158, G159, G160, G164, G171, G172.</p> <p>o Failure to ensure administrative and supervisory functions are being performed effectively and ensuring that: agency policies and procedures are implemented consistently; case management activities are being performed consistently; the plan of care is reviewed to ensure that it addresses all identified patient needs; the plan is being followed as written; nursing assessments and reassessments are complete. See G 133, G140</p> <p>o Failure to ensure effective communication and coordination between all disciplines including supervisory staff as outlined in agency policy. G143</p> <p>o Failure to ensure complete, accurate, and current documentation is readily available. G 236</p> <p>o Failure to ensure internal quality improvement audits are provided to the governing body and are of sufficient scope to identify the areas in need of improvement. See G250</p> <p>The cumulative effect of these systemic problems resulted in the home care agency's failure to ensure the provision of quality health care. Additionally, this failure to provide oversight of the agency resulted in a negative outcome for patients # 1, 2, 6, 8, 11, 13, and potential negative outcomes for the agency's entire patient population.</p> <p>Three previous recertification surveys, dated 01/24/07, 11/08/04 and 03/29/04 identified the agency's failure to: ensure adequate initial skilled</p>	G 122	<p>actions to ensure that the assessments and care plans for all patients who remain on service are current, accurate, complete, and comprehensive by 1/15/08.</p> <p>The Governing Authority will communicate on a weekly basis with the Agency Administrator (AA) and Director of Patient Services (DPS) to discuss progress made toward implementing the Plan of Correction to address deficiencies identified by New York State Department of Health (DOH) in past surveys and the most recent survey completed 12/19/07.</p> <p>The DPS and or Designee will review the policies and procedures identified below to determine if they are of sufficient scope to address areas identified to be deficient in the 12/19/07 DOH survey and in past surveys. Revisions will be made as required and staff will receive required education in the revisions and in related professional standards of practice by 1/15/08.</p> <ul style="list-style-type: none"> <li>• Promotion and protection of Patient Rights by agency staff with a focus on, but not limited to ensuring that patient's participate in care plan development and changes and that no care plan is implement prior to patient approval (see G109)</li> <li>• Case management and coordination to include structured case conferencing (see G143)</li> <li>• Provision of care as specified in the plan (see G158)</li> </ul>	<p>1/15/08</p> <p>1/15/08</p>

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G 122	<p>Continued From page 17</p> <p>and quality care is provided to each patient. G 158, G159, G160, G164, G171, G172.</p> <p>o Failure to ensure administrative and supervisory functions are being performed effectively and ensuring that: agency policies and procedures are implemented consistently; case management activities are being performed consistently; the plan of care is reviewed to ensure that it addresses all identified patient needs; the plan is being followed as written; nursing assessments and reassessments are complete. See G 133, G140</p> <p>o Failure to ensure effective communication and coordination between all disciplines including supervisory staff as outlined in agency policy. G143</p> <p>o Failure to ensure complete, accurate, and current documentation is readily available. G 236</p> <p>o Failure to ensure internal quality improvement audits are provided to the governing body and are of sufficient scope to identify the areas in need of improvement. See G250</p> <p>The cumulative effect of these systemic problems resulted in the home care agency's failure to ensure the provision of quality health care. Additionally, this failure to provide oversight of the agency resulted in a negative outcome for patients # 1, 2, 6, 8, 11, 13, and potential negative outcomes for the agency's entire patient population.</p> <p>Three previous recertification surveys, dated 01/24/07, 11/08/04 and 03/29/04 identified the agency's failure to: ensure adequate initial skilled</p>	G 122	<ul style="list-style-type: none"> <li>• Development of complete and accurate care plans (see G159)</li> <li>• Complete and accurate nursing assessments and reassessments that identify significant patient symptoms, address priority needs and immediate reporting of changes in patient condition to the physician (see G 171, G172)</li> <li>• Qualified and knowledgeable nursing staff (see G174)</li> <li>• Nursing Supervision</li> <li>• Readily available complete, accurate clinical records that reflect current patient status (see G236)</li> </ul> <p>The DPS and or Designee will develop and implement by <b>01/15/08</b> a plan to audit each case managers case load every 2 weeks (weekly at present) for effective case management and to audit each case managers patient start of care, restart of care, and recertification assessment and plan of care for completeness and accuracy (See G109, G143, G158, G159, G171, G172, G174, G236).</p> <p>The DPS or Designee will trend audit <u>data by group and by individual</u>. This data will be presented to the PAC and Governing Authority. Areas in need of improvement will be identified, corrective action planed, implemented, and monitored. The above audits will begin by <b>01/15/08</b> (see G250).</p>	1/15/08

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G 122	Continued From page 18 nursing assessments; ensure adequate skilled nursing reassessments; develop complete and accurate plans of care.  Two previousl recertification surveys dated 11/08/04 and 03/29/04 identified the agency's failure to: coordinate patient care; provide adequate nursing supervision.  The agency has demonstrated a repeated failure to develop strategies to comply with the requirements pertaining to: development and implementation of the plan of care; coordinate patient care; performing adequate initial and follow up nursing assessments; supervise the nursing staff.	G 122	<b>G128 GOVERNING BODY</b>  The Governing Authority met on 12/14/07 and appointed Mary Elizabeth Harrington as Interim Agency Administrator.  The Agency Administrator met with the Governing Authority on 12/31/07 and; * Reviewed and accepted the draft Plan of Care Correction (POC) developed to address deficiencies identified as a result of the NYS DOH survey completed on 12/19/07. The POC will also address deficiencies identified as a result of past DOH surveys. Resources required to implement the plan were also approved. * Reviewed and accepted the resignation of Karen Haesloop, Director of Patient Services (DPS). Karen's last day will be 1/4/08. * Approved the appointment of Carol J. Henderson to the position of DPS after review and approval by NYS DOH. * Addendum: 1/2/08, Lynn Shannon, NYS DOH notified the agency Administrator that Carol Henderson could fill the role of DPS in an acting capacity while the agency continues their recruitment efforts. Carol Henderson was offered the position and she accepted it. The agency continues their recruitment through Career Builder and ads will appear in the Ithaca, Rochester, and Binghamton newspapers.	12/14/07  12/31/07  1/4/08  1/2/08	
G 128	484.14(b) GOVERNING BODY  A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.  This STANDARD is not met as evidenced by: Based on a review of 22 clinical records, 5 observational home visits, review of PAC meeting minutes, and governing body meeting minutes, and interviews with the Agency Administrator (AA), Director of Nursing (DON), and Agency Consultant, and agency staff, evidence is lacking in 20 records the governing body effectively oversees the operation and management of the agency. Patients #1 - 17, 19, 21, 22  Failure of the governing body to provide adequate oversight and direction of the agency resulted in negative patient outcomes for patients # 1, 2, 6, 8, 11, 13, multiple repeat standard level deficiencies, and multiple condition level	G 128			

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NAME OF PROVIDER OR SUPPLIER  <b>VNS ITHACA TOMPKINS CO CHHA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>138 CECIL A MALONE DRIVE</b> <b>ITHACA, NY 14850</b>		
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G 122	Continued From page 18 nursing assessments; ensure adequate skilled nursing reassessments; develop complete and accurate plans of care.  Two previous recertification surveys dated 11/08/04 and 03/29/04 identified the agency's failure to: coordinate patient care; provide adequate nursing supervision.  The agency has demonstrated a repeated failure to develop strategies to comply with the requirements pertaining to: development and implementation of the plan of care; coordinate patient care; performing adequate initial and follow up nursing assessments; supervise the nursing staff.	G 122	<b>G128 GOVERNING BODY</b>  * Agreed with the recommendation by the AA and DPS that until further notice no new patients should be admitted to the agency, unless under special circumstances as approved by the AA and DPS. The agency will open to admissions only after the agency has come back into full compliance with the Conditions of Participation and the AA and DPS report that the agency has made acceptable progress in correcting quality of care issues.  * Directed the DPS and or Designee to take required actions to ensure that the assessment and care plans for all patients who remain on service are current, accurate, complete, and comprehensive by 1/15/08.		12/31/07
G 128	<b>484.14(b) GOVERNING BODY</b>  A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.  This STANDARD is not met as evidenced by: Based on a review of 22 clinical records, 5 observational home visits, review of PAC meeting minutes, and governing body meeting minutes, and interviews with the Agency Administrator (AA), Director of Nursing (DON), and Agency Consultant, and agency staff, evidence is lacking in 20 records the governing body effectively oversees the operation and management of the agency. Patients #1 - 17, 19, 21, 22  Failure of the governing body to provide adequate oversight and direction of the agency resulted in negative patient outcomes for patients # 1, 2, 6, 8, 11, 13, multiple repeat standard level deficiencies, and multiple condition level	G 128	* Directed the AA, DPS, or Designee to revise and intensify the agency's quality improvement program and to review and revise as appropriate all other policies and procedures identified in the POC by <b>01/08/08</b> , with overall policy and procedure and administrative review by <b>03/01/08</b> .		1/15/08  1/8/08 3/1/08

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G 122	Continued From page 18 nursing assessments; ensure adequate skilled nursing reassessments; develop complete and accurate plans of care.  Two previous recertification surveys dated 11/08/04 and 03/29/04 identified the agency's failure to: coordinate patient care; provide adequate nursing supervision.  The agency has demonstrated a repeated failure to develop strategies to comply with the requirements pertaining to: development and implementation of the plan of care; coordinate patient care; performing adequate initial and follow up nursing assessments; supervise the nursing staff.	G 122		1/8/08 3/21/08	
G 128	484.14(b) GOVERNING BODY  A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.  This STANDARD is not met as evidenced by: Based on a review of 22 clinical records, 5 observational home visits, review of PAC meeting minutes, and governing body meeting minutes, and interviews with the Agency Administrator (AA), Director of Nursing (DON), and Agency Consultant, and agency staff, evidence is lacking in 20 records the governing body effectively oversees the operation and management of the agency. Patients #1 - 17, 19, 21, 22  Failure of the governing body to provide adequate oversight and direction of the agency resulted in negative patient outcomes for patients # 1, 2, 6, 8, 11, 13, multiple repeat standard level deficiencies, and multiple condition level	G 128	The Governing Authority will meet communicate weekly, until further notice, with the AA and or DPS. The AA will 1) designate a recorder to take minutes at all meetings, 2) review the minutes for accuracy, clarity, and actions to be taken regarding problems identified, 3) take steps ensure that appropriate action is taken, 4) be prepared to report on the actions taken at the next meeting, and 5) maintain a copy of all minutes of the meetings in a location that ensures ready availability and accessibility, AA's office.		



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G 128	<p>Continued From page 19 deficiencies as outlined in the body of this report.</p> <p>Specifically, evidence is lacking that the following governing body responsibilities are being performed:</p> <ul style="list-style-type: none"> <li>o Ensuring that supervision of all patient care is provided and readily available. Specifically that supervisors are ensuring that: patient rights are being protected and promoted; case coordination is being performed; plans of care are complete and being implemented; changes in patient condition are being reported to the physician; nursing assessments are complete and accurate; nurses are qualified and knowledgeable; clinical records are complete, accurate, and readily available. See G 109, G 143, G 158, G 159, G 164, G 171, G 172, G 174, G 229, G 236</li> <li>On 10/12/07 the surveyor interviewed the AA. The AA stated the Nursing Supervisor had resigned the end 09/21/07, and she had been fulfilling the roles of Agency Administrator, Director of Patient Services, Director of Nursing, and Nursing Supervisor.</li> <li>o Ensuring that services provided are of sufficient quality to meet the needs of its patient population. See G 143, G 158, G 159, G 164, G 171, G 172, G 174, G 250</li> <li>o Ensuring all complaints are adequately documented, investigated, and resolved. See G 133</li> <li>o Ensuring internal agency audits are of sufficient scope to identify quality of care issues and that resolutions are developed and implemented. See G 250</li> </ul>	G 128	<p>The following will be discussed:</p> <ol style="list-style-type: none"> <li>1) Overall Progress made toward implementation of the Plan of Correction to address deficiencies identified on the DOH survey completed 12/19/07 at the agency</li> <li>2) Status of assessment and care planning review and or revisions for all patients who remain on service to be completed by 1/15/08</li> <li>3) Status/results of skills competency assessment to include observational visit for all nurses on staff to be completed by 1/04/08</li> <li>4) Results of complaint investigation or of patient satisfaction surveys</li> <li>5) Data related to compliance with requirement that nurses complete documentation within 24 hours of patient visit</li> <li>6) Progress made toward developing strategies to ensure that patient rights are protected and promoted by agency staff (see G109).</li> <li>7) Progress made toward developing description of roles and responsibilities of the Agency Administrator, Director of Patient Services, Supervising Nurse and Quality Improvement nurse to be completed by 1/15/08.</li> <li>8) Results of quality assurance audits, concurrent and retrospective, of sufficient scope to ensure that care is of sufficient quality; patient rights are being protected and promoted; case coordination is being performed; plans of care are complete and being</li> </ol>	1/15/08  1/4/08  1/15/08	

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G 128	Continued From page 20  o Ensuring that the agency's record keeping system provides a mechanism to ensure the patient record includes: an accurate plan of care which addresses each patient's needs; assessments which readily identify the patient's response to treatment and change in status; a current representation of the patient's condition. See G143, G159, G164, G168, G171, G172, G236, G250  o Ensuring the agency is consistently functioning in full compliance with all applicable rules and regulations as outlined in this report.	G 128	implemented; changes in patient condition are being reported to the physician; nursing assessments are complete and accurate; nurses are qualified and knowledgeable; clinical records are complete, accurate. (See G109, G143 G158, G159, G164, G171, G172, G174, G229, G236, G250).  9) Data required to complete the annual evaluation in sufficient scope to determine the extent that the agency's services are appropriate, adequate, effective and efficient by 3/01/08 (see G245)	3/1/08	
G 133	484.14(c) ADMINISTRATOR  The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.  This STANDARD is not met as evidenced by: Based on review of 22 clinical records, 5 observational home visits, interviews with the Agency Administrator (AA), Director of Nursing (DON), and agency staff, review of personnel records, agency policy and procedures, minutes of the Professional Advisory Committee, governing body meeting minutes, evidence is lacking in 20 records the AA effectively oversees the operation and management of the agency. Patients # 1 - 17, 19, 21, 22)  Failure of the Agency Administrator to provide adequate oversight and direction of the agency resulted in negative patient outcomes for patients	G 133	<b>G133 ADMINISTRATOR</b>  The Agency Administrator (AA) and Director of Patient Services will review/revise the existing job description delineating the roles and responsibilities of the AA by 1/08/08. The revised job description will be presented to the Professional Advisory Committee (PAC) for review and approval by 1/10/08 and to the Governing Authority by 1/15/08 for review and approval.  The revisions will include delineation of the AA roles and responsibilities in the organization and direction of the agency's ongoing functions to include but not be limited to:  • Implementing an effective quality improvement program that promotes	1/08/08  1/10/08  1/15/08	

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G 133	<p>Continued From page 21</p> <p># 1, 2, 6, 8, 11, 13, multiple repeat standard level deficiencies and multiple condition level deficiencies as outlined in the body of this report; and has the potential for agency wide negative patient outcomes.</p> <p>Specifically, evidence is lacking the following responsibilities of the Administrator are being performed:</p> <ul style="list-style-type: none"> <li>o Ensuring that all patient rights are being protected and promoted. See G 109</li> <li>o Ensuring an effective plan is implemented to correct deficiencies cited in all surveys.</li> </ul> <p>Specifically, Three previous recertification surveys, dated 01/24/07, 11/08/04 and 03/29/04 identified the agency's failure to: ensure adequate initial skilled nursing assessments; ensure adequate skilled nursing reassessments; develop complete and accurate plans of care.</p> <p>Two previous recertification surveys dated 11/08/04 and 03/29/04 identified the agency's failure to: coordinate patient care; provide adequate nursing supervision.</p> <ul style="list-style-type: none"> <li>o Ensuring internal quality improvement audits provided to the governing body are of sufficient scope to identify the areas in need of improvement, and that the governing body is informed of the agency's overall status with respect to compliance and quality issues. See G250</li> <li>o Ensuring that the agency's record keeping system provides the following essential components in a timely manner: a mechanism to</li> </ul>	G 133	<p>quality patient care and identifies and corrects areas in need of improvement.</p> <ul style="list-style-type: none"> <li>• Monitoring Plans of Corrections implemented as a result of DOH surveys to determine effectiveness in resolving deficient areas</li> <li>• Providing PAC and the Governing Authority with the following:               <ol style="list-style-type: none"> <li>1. Results of quality assurance audits, concurrent and retrospective, of sufficient scope to ensure that supervisory functions are being performed; agency policies and procedures are implemented consistently; care is of sufficient quality; patient rights are being protected and promoted; case coordination is being performed; plans of care are complete and being implemented; changes in patient condition are being reported to the physician; nursing assessments are complete and accurate; nurses are qualified and knowledgeable; clinical records are complete, accurate. (See G109, G143 G158, G159, G164, G171, G172, G174, G229, G236, G250).</li> <li>2. Data required to complete the annual evaluation by <b>3/01/08</b> and annually thereafter in sufficient scope to determine the extent that the agency's services are appropriate, adequate, effective and efficient (see G245)</li> <li>3. Evaluation of nurse retention problems related to issues of salary and benefits with a proposal for retention by <b>3/01/08</b>.</li> </ol> </li> </ul>	<p>3/01/08</p> <p>too late. 3/01/08</p>	

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G 133	<p>Continued From page 22</p> <p>readily identify the patient's response to treatment and change in status; a current representation of the patient's condition; and a plan of care that is accurate and addresses each patient's needs. See G143, G159, G164, G168, G171, G172, G236, G 250</p> <p>o Ensuring the provision of adequate supervision of patient care and skilled nursing staff. Specifically that supervisors are ensuring: patient rights are being protected and promoted; case coordination is being performed; plans of care are complete and being implemented; changes in patient condition are being reported to the physician; nursing assessments are complete and accurate; nurses are qualified and knowledgeable; clinical records are complete, accurate, and readily available.</p> <p>Although there is evidence the Nursing Supervisor was reviewing open patient records with the Skilled Nurses prior to her departure on 09/21/07, and the AA stated she has been reviewing open patient records with the SNs since that time, evidence is lacking the problems identified by this survey are being identified and/or corrected by the Nursing Supervisor / Agency Administrator. See G 109, G 143, G158, G159, G 164, G171, G172, G 174, G 229, G 236</p> <p>On 10/12/07 the AA was interviewed by the surveyor. The AA confirmed the Nursing Supervisor had resigned on 09/21/07, and she had been fulfilling the roles of Agency Administrator, Director of Patient Services, Director of Nursing, and Nursing Supervisor.</p> <p>On 11/09/07 the AA was interviewed by the</p>	G 133	<p>4. A plan for recruiting Home Health Aides and Personal Care Aides to be developed by <b>3/01/08</b>.</p> <ul style="list-style-type: none"> <li>Meeting with the Governing Authority weekly until further notice or as needed to keep them informed with respect to agency compliance and quality issues to include progress made with implementation of Plan of Correction to address deficiencies identified as a result of the DOH survey completed <b>12/19/07</b>. Results of the evaluation agency's total program to be completed by <b>03/01/08</b>, will be presented to the Governing Authority in <b>03/08</b>. These meetings will begin on <b>12/20/07</b> and</li> </ul> <p>will be ongoing until further notice. The DPH will review the minutes of these meetings for accuracy and clarity in collaboration with the DPS/SPHN and maintain a copy of all meeting minutes in a place that ensures ready accessibility and availability.</p> <ul style="list-style-type: none"> <li>Implementation of policies and procedures to ensuring that plans of care for patients in the Long Term Home Health Care Program are jointly developed with the Department of Social Services (DSS) as required by Title 18 of the NYS Code of Rules and Regulations are correctly implemented and supervised (see G143, G159, G229)</li> <li>Investigation and Resolution of complaints (see G245)</li> </ul>	<p>why so late 3/1/08</p> <p>3/1/08 3/8/08 12/20/07</p> <p>1/15/08 1/15/08</p>

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G 133	<p>Continued From page 23</p> <p>surveyor. The AA stated salary and benefits were causing a high turnover in the nursing staff, which was problematic for the agency, and that a competing agency had higher salaries and better benefits, as well as lower caseloads. The surveyor questioned if the AA had brought this to the attention of the Governing Body. The AA initially stated she had, however, then stated it would not matter if she had because if the agency increased their salaries, the competing agency would do the same. Evidence is lacking however, the issue of salary and benefits was ever discussed with the Governing Body.</p> <p>On 11/13/07 an interview was conducted by the surveyor with the AA and Agency Consultant. The surveyor questioned if the plans of care are reviewed prior to being sent to the physician. The AA stated all plans of care are reviewed by herself or a Nursing Supervisor at the start of care, however, evidence is lacking numerous and serious medication discrepancies are being identified on the plan of care. See G 159</p> <p>o Ensuring appropriate management and coordination of services of the Long Term Home Health Care Program (LTHHCP). A program which provides a coordinated plan of care and services for individuals who would otherwise be medically eligible for placement in a hospital, or residential facility for an extended period of time if such a program were not available.</p> <p>Specifically the AA failed to ensure the plans of care: are jointly developed with the Department of Social Services (DSS), as required by Title 18 of the New York Code of Rules and Regulations (NYCRR); are correctly implemented; are adequately supervised. See G 143, G 158, G229</p>	G 133	<ul style="list-style-type: none"> <li>Implementation of policies and procedures to ensure that the agency's record keeping system provides essential components in a timely manner; a mechanism to readily identify a patient's response to treatment and change in status; a current representation of the patient's condition; and a plan of care that is accurate and addresses all patient needs (see G143, G159, G164, G171, G172, G236, G250)</li> </ul> <p>The AA, DPS, and or Designee will revise and intensify the agency's quality improvement program <u>policies and procedures by 01/08/08.</u></p> <p>The comprehensive audit tool will be revised and will be of sufficient scope to identify areas in need of improvement and effectiveness of the plan of correction to address deficiencies identified</p>	<p>1/15/08</p> <p>1/08/08</p>

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G 133	<p>Continued From page 24</p> <ul style="list-style-type: none"> <li>o Ensuring all complaints are adequately documented, investigated, and resolved. Specifically, patient # 9 was admitted to the agency's LTHHCP on 06/06/07. The patient record contained a letter from the DSS dated 07/09/07 documenting the following concerns: <ul style="list-style-type: none"> <li>- the agency's SN had inaccurately assessed the patient's needs. Specifically, although the SN had just increased her visit frequency due to a decline in patient condition, the SN also assessed the patient's needs were insufficient to qualify for home care services through the LTHHCP.</li> <li>- the agency is not giving the DSS advance notice in the scheduling of joint visits</li> <li>- the services for 2 LTHHCP patients were in jeopardy because the agency had failed to submit their assessments timely to the DSS.</li> </ul> </li> </ul> <p>Additionally, the patient record included evidence that on 07/09/07 the DSS was compelled to obtain a physician override to the SN assessment, thereby ensuring continuation of home care services to the patient through the LTHHCP.</p> <p>On 11/13/07 the surveyor questioned the administrator as to why there was no evidence of a response to the complaint. The AA stated the complaint was sent to the agency's Supervising Nurse, and the AA was not aware of it until 07/24/07 when she had found the letter in the supervisor's desk. Although the AA was in possession of the letter, she took no action to investigate the complaint and resolve the issues identified in the complaint. The AA stated she did not want the supervisor to know she "had gone through her desk".</p>	G 133			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>337212</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/19/2007</b>
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NAME OF PROVIDER OR SUPPLIER

VNS ITHACA TOMPKINS CO CHHA

STREET ADDRESS, CITY, STATE, ZIP CODE

138 CECIL A MALONE DRIVE

ITHACA, NY 14850

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G 133	Continued From page 25 Additionally, the AA failed to investigate why the Nursing Supervisor had not brought the complaint to her (the AA's) attention.	G 133		
G 140	484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE  Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).  This person, or similarly qualified alternate, participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.  This STANDARD is not met as evidenced by: Based on a review of 22 clinical records, 5 observational home visits, interviews with the Agency Administrator (AA) and Director of Nursing (DON), and review of agency policies and procedures, evidence is lacking in 20 records patient # 1 - 17, 19, 21, 22) that the following supervisory responsibilities are being performed:  - Ensuring that patient rights are being protected and promoted. Specifically, ensuring that patients are included in development of the plan of care. See G 109  - Ensuring that coordination/case management is being performed consistently and that all pertinent patient information is communicated to all individuals providing care, and documented in the clinical record. See G 143	G 140	<b>G140 SUPERVISING PHYSICIAN OR REGISTERED NURSE</b>  The DPS presented an overview of the Statement of Deficiencies issued as a result of a NYSDOH survey completed on <b>12/19/07</b> to staff on <b>12/20/07</b> and an in depth review was completed with each case manager and the quality improvement nurse on <b>12/28/07</b> .  The DPS and or Designee will reassess and develop current care plans for the patients identified in the survey who remain on service by <b>1/04/08</b> (8 patients) and for all other patients by <b>1/18/08</b> .  The Agency Administrator (AA) and Director of Patient Services will review/revise the existing job description delineating the roles and responsibilities of the DPS, and quality improvement nurse by <b>1/08/08</b> . The revised job description will be presented to the Professional Advisory Committee (PAC) for review and approval by <b>1/10/08</b> and to the Governing Authority by <b>1/15/08</b> for review and approval.  The DPS and or Designee will review the policies and procedures identified below to determine if they are of sufficient scope to address areas identified to be deficient in the <b>12/19/07</b> DOH survey and in past surveys. Revisions will be made as	12/20/07 12/28/07 1/04/08 1/18/08  1/8/08 1/10/08 1/15/08  7 how can she do this

and in related professional standards  
of practice by 1/15/08.

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G 140	<p>Continued From page 26</p> <ul style="list-style-type: none"> <li>- Ensuring that care provided by all disciplines, follows the written plan of care established by the physician. See G158</li> <li>- Ensuring that each patient's plan of care is complete and accurate for all diagnoses, medications and treatments. See G159</li> <li>- Ensuring that the agency's professional staff promptly alerts the physician to any changes in the patient's condition that may suggest a need to alter the plan of care. See G 164</li> <li>- Ensuring that nursing assessments and reassessments are complete and accurately reflect the patient's status and continuing needs. See G171, G172</li> <li>- Ensuring that nurses providing care requiring special skills are qualified and knowledgeable. See G 174</li> <li>- Ensuring that clinical records are complete, accurate, reflect the patient's current status, and are readily available. See G 236</li> </ul> <p>On 10/12/07 the Agency Administrator was interviewed by the surveyor. The Agency Administrator stated the Nursing Supervisor had resigned the end 09/21/07, and she had been fulfilling the roles of Agency Administrator, Director of Patient Services, Director of Nursing, and Nursing Supervisor.</p> <p>Although there is evidence the Nursing Supervisor was reviewing open patient records with the Skilled Nurses (SN) prior to her departure on 09/21/07, and the Agency Administrator stated she has been reviewing open patient records with</p>	G 140	<ul style="list-style-type: none"> <li>• Promotion and protection of Patient Rights by agency staff with a focus on, but not limited to ensuring that patient's participate in care plan development and changes and that no care plan is implement prior to patient approval (see G109).</li> <li>• Case management and coordination to include structured case conferencing (see G143)</li> <li>• Provision of care as specified in the plan (see G158)</li> <li>• Development of complete and accurate care plans (see G159)</li> <li>• Complete and accurate nursing assessments and reassessments that identify significant patient symptoms, address priority needs and immediate reporting of changes in patient condition to the physician (see G 171, G172)</li> <li>• Qualified and knowledgeable nursing staff (see G174)</li> <li>• Nursing Supervision (G174)</li> <li>• Readily available complete, accurate clinical records that reflect current patient status (see G236)</li> </ul> <p>The DPS and or Designee will develop and implement by <b>01/15/08</b> a plan to audit each case managers case load every 2 weeks (weekly at present) for effective case management and to audit each case managers patient start of care, restart of care, and recertification assessment and plan of care for completeness and accuracy (See G109, G143, G158, G159, G171, G172, G174, G236).</p>		



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G 140	Continued From page 27 the SNs since that time, evidence is lacking the problems identified by this survey are being identified and/or corrected by the Nursing Supervisor / Agency Administrator.  Additionally, although the Agency Administrator stated the initial nursing assessments and plans of care are being reviewed by the Nursing Supervisor / Agency Administrator at the start of care, evidence is lacking problems are being identified and/or corrected as identified by the by this survey.  Failure of the Supervising Nurse / Agency Administrator to provide adequate oversight and direction of the agency resulted in negative patient outcomes for patients # 1, 2, 6, 8, 11, 13, and has resulted in the agency failing to ensure all patient needs are identified and met.	G 140	The DPS and or Designee will complete the following audits to evaluate quality of patient care, effectiveness of actions taken as a result of the plan of correction, compliance with agency policies and procedures and professional standards: 1. Start of care, restart of care, and recertification patient record audits (see G158) 2. Case management audits completed at the time of case conferences or retrospectively (see G143) 3. Comprehensive chart audits 2-4 weeks after the start of care (G250) 4. Quarterly clinical record reviews (G250)		1/15/08 1/15/08 1/15/08 1/15/08
G 143	484.14(g) COORDINATION OF PATIENT SERVICES  All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.  This STANDARD is not met as evidenced by: Based on a review of 22 clinical records, 5 home visits, and review of agency policies and procedures, and interviews with the Agency Administrator (AA), Agency Consultant (AC), and Director of Nursing (DON), evidence is lacking in 8 of 22 records, that the skilled nurses (SN) are consistently functioning in the role of case management/case coordination, or that they have a clear understanding of the role of the home care nurse in providing case management	G 143	The DPS or Designee will trend audit data by group and by individual. This data will be presented to the PAC and Governing Authority. Areas in need of improvement will be identified, corrective action planed, implemented, and monitored. The above audits will begin by 01/15/08 (see G250).  <b>G 143 COORDINATION OF PATIENT SERVICES</b>  Policies and procedures will be of sufficient scope to ensure effective coordination of the efforts of all personnel furnishing services to develop a comprehensive plan of care		1/15/08  <i>What are they</i>

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G 143	<p>Continued From page 28</p> <p>coordination. Patients # 2, 6, 7, 10, 13, 14, 19, 22</p> <p>Lack of adequate case management and case coordination has resulted in a negative outcome for patient # 2, 13, and has the potential for agency wide unmet patient needs and negative patient outcomes.</p> <p>Examples are as follows:</p> <p>1. Patient # 2 was admitted to the agency on 06/06/07 with a primary diagnosis of urinary tract infection, and secondary diagnoses of dehydration, mental disorder, difficulty walking. Despite the assessment of 3 different Skilled Nurses (SNs), and 2 written orders from the physician, indicating the patient was not safe at home alone, and 2 emergent hospital visits, evidence is lacking the agency nurses understood their role as case manager or coordinated appropriate services, to include offering home health aide services, to ensure the patient's safety. Specifically:</p> <p>On 06/06/07 the SN documented the patient had 24 hour aide service provided by a Licensed Home Care Services Agency (LHCSA), however, the son was planning on decreasing the aide service the following week to 12 hours during the day. The SN documented the patient was weak, unsteady, and required 24 hour supervision for safety. The SN recommended the 24 hour aides continue longer until the patient could get up to the commode at night by herself, however it is unclear to whom she made the recommendation to. On 06/11/07 the SN documented the patient was going to be left alone for 12 hours at night starting that day. The SN also documented the</p>	G 143	<p>and to support the objectives outlined in the plan of care to ensure quality patient care.</p> <p>The DPS and/or Designee will review and or revise where appropriate policies and procedures related to case management and coordination by 01/08/08. The DPS and or AA will present the revised policies and procedures to the Professional Advisory Committee (PAC) by 01/09/08 for review and approval and to the Governing Authority for review and approval by 01/10/08.</p> <p>Examples #1 through #7 under this standard are clarified respectively as patients #2, #13, #10, #14, #19, #22, #16; only patients #14, #22 remain on service and will be identified with specific corrective action</p> <p>Revised policies and procedures will clearly delineate the roles and responsibilities of the home care nurse in case management to identifying unmet patient needs and collaboratively develop and effectively coordinate a plan to meet those needs using resources within the agency or in the community including physician. Areas to be addressed are not limited to, however, will include those identified in the most recent and in past DOH surveys as indicated below:</p>	<p>1/8/08</p> <p>1/9/08</p> <p>1/10/08</p>

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G 143	<p>Continued From page 29</p> <p>patient was unable to use the personal emergency response system (PERS) due to dementia.</p> <p>Evidence is lacking the SN: consulted with the Nursing Supervisor, the LHCSA; the patient's son; Adult Protective Services (APS); or the physician until 2 days later on 06/13/07.</p> <p>On 06/13/07 the SN documented she spoke to the physician's nurse and communicated: the patient was home alone at night; the SN advised the patient should not be alone at night for 12 hours; the SN planned to speak to the patient's son.</p> <p>On 06/15/07 the physician wrote an order specifying the patient was not to be left alone for 12 hours. Evidence is lacking the SN followed up with the patient's son, or the LHCSA, regarding the lack of 24 hour supervision per the physician's order, or referred the patient to APS.</p> <p>On 06/15/07 a transfer assessment (OASIS) indicated the patient was seen in the emergency room for nausea, dehydration, malnutrition, constipation, impaction. The SN failed to follow up regarding specific events necessitating the emergent care, or if the patient had been admitted to the hospital.</p> <p>On 06/20/07 the agency resumed patient care, and the Resumption of Care (ROC) assessment stated the patient had been hospitalized for a urinary tract infection, and was now receiving 24 hour aide service through the LHCSA.</p> <p>On 08/06/07 the Nursing Supervisor (NS) began visiting the patient, and the 08/06/07 progress</p>	G 143	<ol style="list-style-type: none"> <li>1) Protection and promotion of patient rights; Patient/caregiver participation in care plan development and with changes and agreement prior to implementation; assessment of patient and or caregiver abilities to perform tasks with teaching where appropriate to ensure competency; accurate assessment of funding sources available to pay for required services with effective coordination (patient #13 no longer on service) (also, see G 109)</li> <li>2) Assessment of, advocacy for, and effective coordination of care for patient's requiring 24 hour supervision to ensure safety (patient's #2, #13 no longer on service).</li> <li>3) Referral to and coordination with disciplines within the agency such as, but not limited to social work (patient #10 no longer on service)</li> <li>4) Referral to and coordination with resources outside the agency including, but not limited to Adult Protective Services (patient's #2, #10 no longer on service) and to Wound Care Clinics (patient #13 no longer on service)</li> <li>5) Physician coordination to include, but not be limited to; a) notification of additions and or modifications to the plan that are required after the initial evaluation visit has occurred, b) notification of the physician related to changes in the patient's condition, which may warrant a change in the patient's plan of care and discussion of patient discharge from the agency prior to discharge (patient #13 no longer on service) (see G 164)</li> </ol>	

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G 143	<p>Continued From page 30</p> <p>note stated that the patient was safe at home with 24 hour supervision, however; the SN documented on 08/14/07 the aide service had been decreased to 12 hours per day. On 08/28/07 the NS documented the patient was home alone at night, and the record contained an 08/28/07 physician order to the LHCSA, and provided to the surveyor by the AA on 10/31/07, specifying the patient required 24 hour care. Once again the NS failed to take action to ensure the patient's safety, and failed to consult with the physician, patient's son, or APS regarding the patient's unmet safety needs.</p> <p>On 09/04/07 the NS visited the patient and documented the patient: had been hospitalized overnight due to chest pain; had aide service 13 hours per day; "was alone at night even though the physician had suggested she needed 24 hour care"</p> <p>Evidence is lacking the NS: identified the physician had not merely suggested the patient have 24 hour supervision, but had issued written orders for 24 hour supervision on 2 separate occasions, specifically on 06/15/07 and 08/28/07; or understood her role as case manager/nursing supervisor to advocate for the patient, and take action to ensure the patient's safety.</p> <p>On 10/05/07 a different SN visited the patient and documented "the patient stays home all night without any one available to her. The son feels she is fine to do so. Safety is a concern if anything were to happen in the night hours".</p> <p>On 10/17/07 at 2:30 PM the surveyor reviewed the patient's safety issues with the Agency Administrator and Agency Consultant, and</p>	G 143	<p>6) Assistance as required by the patient with procurement of medically necessary supplies and durable medical equipment (patient #10 no longer on service)</p> <p>7) Sufficient coordination to ensure patients receive daily wound care/dressing changes when ordered by the physician (patient #13 no longer on service)</p> <p>8) Delineation of roles and responsibilities of agency and Tompkins County Department of Social Services staff to ensure that patients in the Long Term Home Health Care Program receive quality care in accordance with Federal and State Regulations (patients #19, #16 are no longer on service)</p> <ul style="list-style-type: none"> <li>• Patient #14; Discrepancies in frequency for nursing visits between the agency plan of care and Department of Social Services (DSS) summary of required services will be reconciled at the time of a joint visit to the patient's home between agency and DSS staff to be arranged by 1/04/08. A comprehensive, accurate assessment will be completed and a care plan will be developed to meet the patient's needs by all involved and implemented within 24 hours of the assessment visit.</li> </ul>	1/4/08	

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G 143	<p>Continued From page 31</p> <p>questioned why the SNs or Nursing Supervisor had not referred the patient to APS, and why there was no evidence the physician had been notified the patient was not receiving 24 hour supervision. The Administrator stated:</p> <ul style="list-style-type: none"> <li>- she (the Administrator) did not think the patient required 24 hour supervision</li> <li>- she felt the SN was mistaken, and that she will speak to the SN</li> </ul> <p>On 10/17/07 at 3:30 the surveyor interviewed the SN and the Administrator. The SN stated she stands by her assessment that the patient should not be left alone, and had just referred the patient to APS, and had advised the son on the action she had taken.</p> <p>This record was reviewed with the AA and AC on 10/18/07, no additional information was provided.</p> <p>2. Patient #13 was admitted to the agency on 09/07/07 with a primary diagnosis of left lower leg ulceration. The initial nursing assessment indicated the patient was referred to the agency because the patient was unable to perform dressings independently resulting in maggot infestation of the wound (which was resolved by the wound care center). The plan of care specified daily dressing changes, which included: cleanse wound with normal saline, apply zinc oxide around open areas, apply bactroban to wound beds, cover with silver dressing or xeroform gauze, dry sterile dressing, "ABD pad", secure with kling wrap and ace wrap toes to knee. The SN failed to appropriately coordinate the patient's care to ensure the agency provided daily dressing changes as ordered by the physician, as follows:</p>	G 143	<ul style="list-style-type: none"> <li>• Patient #22; Discrepancies in frequency of HHA/PCA service between the agency plan of care and DSS summary of required services was addressed at the time of a joint visit by agency and DSS staff to the patient's home on 12/17/08. Revisions to the DSS summary of required services and agency plan of care will be completed by 1/04/08. A comprehensive, accurate assessment will be completed and a care plan will be developed to meet the patient's needs by all involved and implemented within 24 hours of the assessment visit.</li> <li>9) Documentation</li> <li>10) Case Conferencing</li> <li>• The DPS or Designee will arrange for case conference meetings to occur every 2 weeks on Wednesdays in the AM (currently weekly) or sooner if dictated by patient care needs (potential with new admission ect.). Professional personnel within the agency providing care to a specific patient will be required to attend (each case manager will maintain a current list of services that the patient is receiving from the agency and in the community at the end of the case conference section in each patient record and a patient care map in the front of each patient record indicating planned agency visits and use of community resources). The case manager will be responsible to ensure that staff required to attend the case conference are present. If staff required to attend are unable, the case manager will be responsible to</li> </ul>	<p>12/17/08</p> <p>1/4/08</p> <p>1/15/08</p> <p>7 C Supervisor</p>	

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G-143	<p>Continued From page 32</p> <p>- On 09/12/07 the SN documented the following communication with the RN team leader: "due to the chronic nature of the patient's wounds, copious wound drainage, and simple dressing change, the patient was not qualifying for continued daily visits from an RN". The SN faxed her findings to the physician, and requested the patient be seen by the wound care center so that the patient could be discharged from home care. Although the dressing change was complex and included 8 steps, and the wound was draining copiously, and not stable, the SN made an arbitrary decision regarding the agency's responsibility to follow the plan of care, and the SN and team leader RN put the decision into action without consulting with the AA/Supervising Nurse. The SN failed to coordinate an appropriate plan with the patient, family, wound center, and physician, for the daily dressing changes.</p> <p>On 09/13/07 the physician responded to the SN's fax by ordering continued daily dressing changes by the SN, and on 09/25/07 the SN sent the patient to the emergency room for maggot reinfection of the wound. The emergency room treated the wound and initiated antibiotics.</p> <p>- On 09/28/07 the SN documented communicating to the patient that Medicare will not pay for daily visits with a chronic non healing wound, and she had the patient sign the "paperwork". The SN again failed to: identify the patient's wound was unstable. Specifically, the patient had been sent to the emergency room 3 days prior for reinfection of maggots, the patient was taking antibiotics as a result of the maggot reinfection, the copious wound drainage was continuing. Again, the SN persisted in making an arbitrary decision regarding the agency's</p>	G 143	<p>communicate with that individual to obtain current assessment data and to identify areas requiring discussion/action. Attendance by patients, caregivers, or other resources is encouraged where appropriate.</p> <ul style="list-style-type: none"> <li>The case manager must report at the case conference information that demonstrates effective interchange, reporting, and coordination with services that the patient is receiving from the agency and outside the agency such as, but not limited to the Wound Care Center and Long Term Home Health Care Program. The information exchanged must be sufficient in scope to ensure effective care planning and meeting of objectives specified in the plan. The case manager will review on a weekly basis or more frequently if required all entries in each patient record (initial end of note) and take appropriate action based on what is identified in the note. The case manager will be responsible to ensure that all action plans are clearly defined and indicate who will take what action. Discussion related to implementation of the plan must be documented in the patient record to include results with evidence of follow up at the next case conference.</li> <li>The case manager will be responsible for documenting the results of the case conference in the patient record in the section labeled Case Conferences and for communicating with those furnishing care that were not present at the case conference pertinent information.</li> </ul>		

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G 143	<p>Continued From page 33</p> <p>responsibility to provide daily dressing changes, and put the decision into action without consulting with the Nursing Supervisor. The SN failed to coordinate an appropriate plan with the patient, family, wound center, and physician, for the daily dressing changes.</p> <p>- On 10/05/07 the SN obtained a physician order to decrease SN visits to one time per week, and indicated the patient's son would performing the daily dressing changes, however, on 10/15/07 the SN documented the son stated the physician will contact social services to see about placing the patient. The son also stated the physician was concerned about the condition of the patient's leg, and would be writing a letter advising that the patient be placed in "rehab" for temporary help. The SN failed to identify or coordinate increased SN visits with the physician until placement could be made, or to possibly avoid the need for placement into a facility.</p> <p>- Although the SN documented 6 times between 10/01/07 and 10/16/07 discussions with the patient, son, and/or physician indicating the patient had a need for long term care in a structured environment such as assisted living or skilled nursing facility, evidence is lacking the SN identified the need for a social work evaluation until 10/23/07 when an observational home visit was made by the surveyor with the SN.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>3. Patient #10 was admitted to the agency on 09/19/07. The plan of care included weekly SN visits for wound assessments of buttocks</p>	G 143	<ul style="list-style-type: none"> <li>Case conferencing with the patient and or caregiver must be part of care planning development and revision and must occur prior to implementation of the initial care plan and any revisions. Evidence of this case conferencing must be documented in the patient record by the clinician discussing the plan or revisions and must delineate the roles and responsibilities of all parties involved, competency in interventions to be provided by the patient and or primary caregiver and patient/caregiver agreement with the plan.</li> </ul> <p>11) <b>Evaluation of Effective case coordination and management on a concurrent basis:</b></p> <p>The DPS or Designee will complete case management audits with each case manager at the patient's <u>start of care and every two weeks thereafter</u>. The audits will be documented on a case management audit tool and will be completed at the time of case conferencing when possible. The <u>criteria identified in the audit tool will be indicators of effective case management and will include but not be limited to areas identified to be deficient in the past and most recent DOH survey</u>. The audits will be completed on 100% of the patients on each case manager's roster. When a case manager reaches a 90% compliance rate with the criteria, the audits will decrease to 50% of the case manager's patient roster every</p>	1/15/08	

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NAME OF PROVIDER OR SUPPLIER

**VNS ITHACA TOMPKINS CO CHHA**

STREET ADDRESS, CITY, STATE, ZIP CODE

**138 CECIL A MALONE DRIVE  
ITHACA, NY 14850**

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G 143	<p>Continued From page 34</p> <p>decubiti, and Physical Therapy (PT) visits every day for 4 days then 2 times per week for 3 weeks for gait training and strengthening. Evidence is lacking the patient's care was coordinated as follows:</p> <p>On 09/20/07, 09/25/07, 10/03/07, and 10/07/07, the PT documented the patient was unhappy with her air mattress and was "fighting" with her insurance company to obtain a better one.</p> <p>On 10/02/07 the Agency Administrator documented the PT would be referring the patient to APS for an unsafe environment and unmet safety needs. The AA documented 3 nurses had been to the patient's home to fix the bed. Evidence is lacking:</p> <ul style="list-style-type: none"> <li>- the SN or PT documented any unmet safety needs of the patient, or whether a better air mattress was indicated</li> <li>- the AA, PT or SN advocated on the patient's behalf with the insurance company and physician to obtain a better air mattress. Specifically, on 12/10/07 the surveyor interviewed the PT and questioned if she felt a new air mattress was needed. The PT stated it was not immediately needed, however, would be beneficial for the long term management of the patient's skin integrity.</li> <li>- The SN consulted with the physician regarding the need for a social work evaluation. Specifically, although the AA documented the patient required the assistance of a case worker from the Department of Social Services, and indicated to the SN the PT made a referral to APS, evidence is lacking the assistance of an agency social worker was ever offered.</li> <li>- the referral was actually made to APS. Specifically, on 12/10/07 the PT stated to the</li> </ul>	G 143	<p>two weeks. If at any time the case manager's compliance rate drops below 90%, the audit frequency rate will return to 100%. If ineffective case management is identified at the time of the audit, the DPS or Designee will collaborate with the case manager to develop, implement, and follow up on corrective actions.</p> <p>The DPS or Designee will maintain the results of initial and ongoing case management audits by patient, alphabetically, in a notebook that will be labeled Patient Care Conferencing/Audits. The notebook will be maintained in the DPS or Designee office. After the patient is discharged from the agency the DPS or Designee will remove the patient specific case conferencing/auditing data from the notebook and request that support staff file the information by patient, by month of discharge, alphabetically, in a cabinet in the locked medical record room.</p> <p>The DPS or Designee will trend the results of the audits by group and by individual on a monthly basis or more frequently if results indicate a less than 90% compliance rate (weekly at present).</p> <p>The DPS and or Designee will meet with the AA on a monthly basis (1<sup>st</sup> Tuesday of each month) or more frequently if compliance rates are below 90% (weekly at present) to discuss and analyze the results of the audits. Areas identified to be in need</p>	<p>12/10/08</p>



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G 143	<p>Continued From page 35</p> <p>surveyor that she had reported to the AA there were no unmet safety needs, and so she had never made the referral to APS. The patient record failed to document this.</p> <p>- On 10/15/07 the SN faxed a note to the physician indicating the patient had been discharged from nursing services 10 days prior on 10/05/07. Evidence is lacking the SN followed up on the patient's safety needs, or consulted with the physician prior to discharging the patient.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>4. Patient #14 was admitted to the agency's Long Term Health Care Program (LTHHCP) on 5/25/07 with a diagnosis of Huntington's Chorea. The 5/25/2007- 9/25/2007 Department of Social Services (DSS) summary of required services included SN visits every week, however the 07/24/07 agency plan of care included SN visits every other week, and the 09/20/07 agency plan of care included SN visits 1-2 times per week. Evidence is lacking the agency identified, communicated, and resolved this discrepancy with the DSS.</p> <p>5. Patient # 19 was admitted to the agency's LTHHCP on 11/04/03. The 06/10/06 - 10/10/06 DSS summary of required services included Personal Care Aide (PCA) services for 10 hours per week, however, the 06/21/07 agency plan of care included PCA services for only 7 hours per week, and the 08/20/06 agency plan of care included PCA services for only 4 - 9 hours per week. Evidence is lacking the agency identified,</p>	G 143	<p>monitored. Corrective actions planned may be by group or by individual.</p> <p>The DPS or Designee will provide the agency Human Resources Designee with a copy of individual audit trending results for filing in that individuals personnel file for use in staff development and performance evaluations.</p> <p>The DPS or Designee will provide the PAC and Governing Authority with the trended case management audit results and individual audit findings quarterly or sooner based on results for review and action.</p> <p><b>12) Evaluation of effective case management on retrospective basis is incorporated into the 2 to 4 week record review process and quarterly clinical record review process (see 250 )</b></p> <p>The DPS and or Designee will meet with staff from Tompkins County Department of Social Services (DSS) by <b>1/16/08</b> to discuss roles and responsibilities related to effective coordination of care to patients in the Long Term Home Health Care Program. The DPS contacted DSS staff by telephone on <b>12/28/07</b> (minutes of this contact were completed by the DPS and are maintained in the notebook labeled Meeting Minutes) to discuss the</p>	<p>1/15/08</p> <p>1/15/08</p> <p>01/15/08</p> <p>1/10/08</p> <p>12/28/07</p>

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G 143	<p>Continued From page 35</p> <p>surveyor that she had reported to the AA there were no unmet safety needs, and so she had never made the referral to APS. The patient record failed to document this.</p> <p>- On 10/15/07 the SN faxed a note to the physician indicating the patient had been discharged from nursing services 10 days prior on 10/05/07. Evidence is lacking the SN followed up on the patient's safety needs, or consulted with the physician prior to discharging the patient.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>4. Patient #14 was admitted to the agency's Long Term Health Care Program (LTHHCP) on 5/25/07 with a diagnosis of Huntington's Chorea. The 5/25/2007- 9/25/2007 Department of Social Services (DSS) summary of required services included SN visits every week, however the 07/24/07 agency plan of care included SN visits every other week, and the 09/20/07 agency plan of care included SN visits 1-2 times per week. Evidence is lacking the agency identified, communicated, and resolved this discrepancy with the DSS.</p> <p>5. Patient # 19 was admitted to the agency's LTHHCP on 11/04/03. The 06/10/06 - 10/10/06 DSS summary of required services included Personal Care Aide (PCA) services for 10 hours per week, however, the 06/21/07 agency plan of care included PCA services for only 7 hours per week, and the 08/20/06 agency plan of care included PCA services for only 4 - 9 hours per week. Evidence is lacking the agency identified,</p>	G 143	<p>scheduling of joint visits with patients one week in advance. DSS staff voiced agreement. The DPS advised that a goal was to promote quality care and ensure consistency between agency and DSS plans of care. The DPS added that missed visit reports will now be sent to DSS on a regular basis as they occur. A meeting with the agency, DSS on a State and County level, and DOH was previously scheduled, but canceled. The agency looks forward to rescheduling of that meeting.</p> <p>The DPS and or Designee will present an in-service on the revised case management/coordination policies and procedures to Home Care staff by <b>01/10/08</b> with follow up in-service for those required to attend that did not by <b>01/14/08</b>. The revised policies and procedures will be implemented by <b>01/15/08</b></p> <p>The DPS and or Designee will review and revise as necessary the patient satisfaction survey to ensure that information regarding agency performance in the area of case management is included by <b>01/08/08</b>. The DPS and or AA will present the revised policies and procedures to the Professional Advisory Committee (PAC) by <b>01/09/08</b> for review and approval and to the Governing Authority for review and approval by <b>01/10/08</b>. Required revisions will be implemented in the February 2008 Patient Satisfaction Surveys mailings.</p>	<p>1/10/08</p> <p>1/14/08</p> <p>1/15/08</p> <p>1/8/08</p> <p>1/9/08</p> <p>1/10/08</p>	

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G 143	Continued From page 36 communicated, and resolved this discrepancy with the DSS.  This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.  6. Patient #22 was admitted to the agency's LTHHCP on 12/11/06. The 08/11/07 - 12/11/07 DSS summary of required services included Home Health Aide (HHA)/PCA service for 15 hours per week, however, the 08/08/07 and 10/07/07 agency plans of care included HHA/PCA service for 13 hours per week. Evidence is lacking the agency identified, communicated, and resolved this discrepancy with the DSS.  This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.  7. Patient #16, was admitted to the agency on 03/07/07. The 04/13/07 - 08/13/07 and 08/13/07 - 12/13/07 DSS summaries of required services included monthly SN visits, however the 07/05/07 agency plan of care specified SN visits every other week. Evidence is lacking the agency identified, communicated, and resolved this discrepancy with the DSS.	G 143	The DPS and or Designee will arrange for a source outside the agency to present an in service to staff related to effective case management/coordination by <b>01/15/08</b> .  The DPS and or Designee maintain documentation of all in service and attendees in a notebook labeled In Service Education and the notebook will be maintained in the DPS office.  The DPS and or Designee will arrange for minutes of meetings to be taken and the minutes will be maintained in a notebook labeled Meeting Minutes in the DPS office.  <b>G156 ACCEPTANCE OF PATIENTS, POC, MEDICAL SUPERVISION.</b>  The DPS and or Designee will review/revise and <b>implement</b> policies and procedures by <b>1/15/08</b> related to the following: <ul style="list-style-type: none"><li>• Complete and accurate nursing assessments and reassessments that identify significant patient symptoms, address priority needs and immediate reporting of changes in patient condition to the physician (see G164, G171, G172)</li><li>• Development of complete, accurate, individualized care plans which include specific interventions to adequately assess and treat patient conditions and address significant symptoms. (see G159)</li></ul>		1/15/08  1/15/08  1/15/08
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  This CONDITION is not met as evidenced by: o Failure to implement a system which ensures: that plans of care are comprehensive and	G 156			

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G 156	Continued From page 37 address each patient's needs. This survey identifies the agency's failure to develop individualized plans of care which include specific interventions necessary to adequately assess and treat patient conditions and address significant patient symptoms. G159  o Failure to ensure skilled nursing assessments are comprehensive, and identify patient specific needs and develop individualized plans of care. G171  o Failure to consult with the physician after an initial nursing assessment to discuss modifications or changes in the plan of care. G160  o Failure to consistently alert the physician when changes in the patient's condition suggest a need to modify the plan of care. G164  o Failure to consistently follow a written plan of care. G158  The cumulative effect of these systemic problems in the development and implementation of the plan of care resulted in a negative outcome for patients # 1, 2, 11, 13, and the potential for negative outcomes for the agency's patient population and the potential for unmet patient needs.	G 156	<ul style="list-style-type: none"> <li>Provision of care as specified in the plan (see G158)</li> <li>Complete and accurate nursing assessments and reassessments that identify significant patient symptoms, address priority needs and immediate reporting of changes in patient condition to the physician (see G164, G171, G172)</li> </ul> <p>The DPS and or Designee will arrange for nursing staff to attend all required in services related to implementation of policies and procedures identified above by 1/15/08.</p> <p>The DPS or Designee will arrange for nursing staff to attend educational training in areas of nursing practice in which deficiencies were identified through past and recent DOH surveys by, 1/15/08, and on an ongoing basis as identified through agency quality improvement activities and by staff.</p> <p>The DPS and or Designee will develop and implement by 01/15/08 a plan to audit each case managers patient roster every 2 weeks (weekly at present) for effective case management and to audit each case managers patient start of care, restart of care, and recertification assessment and plan of care for completeness and accuracy (See G158, G159, G171, G172, G160, G164).</p> <p>The DPS or Designee will complete retrospective audits for compliance through the 2 to 4 week record review process and the quarterly clinical record review process (see G250).</p>	1/15/08
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.	G 158		1/15/08

**G158 ACCEPTANCE OF  
PATIENTS, POC, MEDICAL  
SUPERVISION**

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G 158	<p>Continued From page 39</p> <p>the front hallway, which is where the SN conducted the assessment. Evidence is lacking the SN assessed the patient's emotional status per the plan of care, or reported the patient's refusal to allow the SN into the home to the physician and/or nursing supervisor. Additionally, evidence is lacking the SN ever revisited the patient to reassess his emotional status per the plan of care.</p> <p>- On 05/24/07 the SN obtained a physician order to decrease SN visits from weekly to 1 - 2 times per month. Evidence is lacking the SN visited the patient to assess his emotional status, or reported the patient's emotional status to the physician, prior to obtaining the order, or consulted with the physician prior to decreasing the frequency of SN visits. Specifically, the SN failed to visit the patient from 05/03/07 - 05/17/07. Additionally, the SN inappropriately obtained a verbal order on 05/24/07 which was backdated to 05/06/07.</p> <p>- On 06/05/07 the SN attempted to visit the patient, however, the wife reported that she was unwilling to accept a visit because they were moving soon. Evidence is lacking the SN reported to the physician the SN was unable to visit the patient, or that the patient's emotional status had not been assessed since admission on 05/03/07.</p> <p>- On 06/07/07 the SN documented the patient was admitted to the hospital for an apparent suicide attempt. The patient's hospital record documented a 06/22/07 discharge diagnosis of suicide attempt. Evidence is lacking the SN had ever reassessed the patient's emotional status following the initial nursing assessment per the plan of care.</p>	G 158	<ul style="list-style-type: none"> <li>Provision of Skilled Nurse visits at frequency specified in plan (patient's #11, #4, #2, #16 are no longer on service); Patients #14, #17 are Long Term Home Health Care Program patients and a joint visit with agency and DSS staff will be completed by <b>1/4/08</b>; A comprehensive, accurate assessment will be completed, discrepancies will be resolved to include those regarding frequency for skilled nurse visits and a care plan will be developed to meet the patient's needs by and implemented within 24 hours of the assessment visit.</li> <li>Provision of aide service at frequency specified in plan (patient #22 is a Long Term Home Health Care Program patient and a joint visit with agency and DSS staff will be completed by <b>1/4/08</b>; A comprehensive, accurate assessment will be completed, discrepancies will be resolved to include those regarding frequency for aide visits and a care plan will be developed to meet the patient's needs by and implemented within 24 hours of the assessment visit.</li> <li>to resolve discrepancies in care plan visit frequency for aide service after which service will be provided at frequency specified (see G133 for aide recruitment efforts)</li> <li>Immediate communication with the physician if all or any part of the initial nursing assessment cannot be completed within the timeframe</li> </ul>	<p>1/4/08</p> <p>1/4/08</p>

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G 158	<p>Continued From page 40</p> <p>The record was reviewed with the AA and the DON on 11/13/2007. The AA stated that the patient should never have been admitted to the agency when a psychiatric problem was identified since a psychiatric nurse was not available for an evaluation.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>2. Patient #2 was admitted to the agency on 06/06/07. The plan of care included SN assessment 1-2 times per week, and report to the physician, signs and symptoms of urinary tract infection and urine retention every visit, private aides to record intake and output (I and O) and SN to monitor; blood pressure should be reported to the physician if it falls below 100/60.</p> <p>Evidence is lacking the SN ever monitored the patient for intake and output, or reviewed the I and O records being kept by the patient's private aides.</p> <p>On 06/20/07 the SN documented the patient had returned home following a hospitalization for a urinary tract infection and the agency had resumed care. The assessment indicated an indwelling urinary catheter had been placed during the hospitalization. The plan of care was updated to include: SN visits twice weekly; Evidence is lacking the SN ever monitored if the aides were continuing to maintain I and O records per the plan of care, or reported the following changes in patient condition to the physician per the plan of care:</p> <p>- On 06/26/07 the SN documented the patient</p>	G 158	<p>specified by the physician; no back dating of physician orders to cover frequency of visits completed as opposed to frequency ordered (patient #11 no longer on service)</p> <ul style="list-style-type: none"> <li>• Complete, accurate assessment of emotional status to include anxiety, anger, depression (patient #11 no longer on service).</li> <li>• Timely documentation of nurse visits; agency policy indicates documentation is to be completed within 24 hours after the visit (patients #4, #14 no longer on service)</li> <li>• Assessment of intake and output and for knowledge deficits and compliance with medication regime (patient #2 no longer on service)</li> <li>• Reporting of changes in the patient's condition and assessment data that falls into the established reporting parameters to the physician (patient #2 no longer on service)</li> <li>• Management of indwelling foley catheters to include timeliness of replacement in the event the foley falls out (patient #2 no longer on service)</li> <li>• Effective coordination of and conformance with wound care orders</li> </ul> <p>to include daily wound care (patients #6, #4 no longer on service) Consistent accurate assessment of edema in accordance with professional standards (patient #13)</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>VNS ITHACA TOMPKINS CO CHHA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>138 CECIL A MALONE DRIVE</b> <b>ITHACA, NY 14850</b>		
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G 158	<p>Continued From page 41</p> <p>was dehydrated, hands trembling, lips sucked in from lack of fluids.</p> <p>- On 07/17/07 the SN documented the patient was voiding every 3 - 4 hours and there was amber urine in the commode, however, evidence is lacking the indwelling urinary catheter had been discontinued.</p> <p>- On 07/24/07 the SN visited the patient and documented the plan included reinforcing catheter care with the aides, however, evidence is lacking the urinary catheter had been reinserted.</p> <p>- the patients blood pressure was below 100/60 on 08/02/07, 08/03/07, 08/04/07</p> <p>Additionally, on 07/05/07 the SN documented she instructed the caregiver to increase colace from as needed to twice daily, however, the plan of care indicated the patient should have already been receiving the colace twice daily on a regular basis.</p> <p>Additionally, the SN failed to visit the patient 2 times per week per the updated plan of care. Specifically, the SN visited only weekly from 06/26/07 to 07/31/07.</p> <p>On 08/05/07 the plan of care specified blood pressures below 90/60 should be reported to the physician. The SN failed to report the following changes in patient condition per the plan of care:</p> <p>- the patient's blood pressure was below 90/60 on 08/10/07, 08/11/07, 08/15/07, 08/26/07.</p> <p>- on 08/14/07 the SN documented the patient had blood clots in her urine</p>	G 158	<p>The DPS has reinforced the agency policy requiring completion of documentation within 24 hours of the visit with nursing staff on a daily basis. A revised compliance monitoring plan will be developed and implemented by 1/15/08 (see G236).</p> <p><b>Evaluation of provision of care in accordance with plan on a concurrent basis:</b></p> <p>The DPS and or Designee will assess compliance with the above on a concurrent basis through participation in patient case conferences conducted at the patient's start of care and every 2 weeks thereafter, and through case management audits beginning 01/15/08 (see G143)</p> <p><b>Evaluation of provision of care in accordance with plan on a retrospective basis is incorporated into the 2 to 4 week record review process and the quarterly clinical record review process (see G250).</b></p>	<p>12/19/07</p> <p>1/15/08</p> <p>1/15/08</p> <p>1/15/08</p>	



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NAME OF PROVIDER OR SUPPLIER

**VNS ITHACA TOMPKINS CO CHHA**

STREET ADDRESS, CITY, STATE, ZIP CODE

**138 CECIL A MALONE DRIVE  
ITHACA, NY 14850**

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G 158	<p>Continued From page 42</p> <p>Additionally, on 09/24/07 the SN visited the patient and documented the patient's urinary catheter came out the morning of 09/23/07 (Sunday), and this had been reported to the agency's on call nurse by the aide at that time. The SN documented the on call nurse instructed the aide to put a diaper on the patient, and the SN would be out on 09/24/07. The on call nurse failed to visit the patient to assess if the patient was able to void following the dislodgement of the catheter. The patient's urinary status, including the patient's ability to void, was not assessed until a full day later on the morning of 09/24/07.</p> <p>This record was reviewed with the AA and AC on 10/18/07, no additional information was provided.</p> <p>3. Patient # 4 was admitted to the agency on 09/26/07 with a primary diagnosis of uncontrolled diabetes, and secondary diagnosis of foot ulcer. The plan of care included daily dressing changes. Evidence is lacking the SN visited daily from 09/26/07 - 10/16/07, or that the SN observed the primary caregiver performing the dressing independently. Specifically, the SN documented performing the dressing change only on 09/26/07, 09/29/07, 09/30/07, 10/01/07.</p> <p>On 10/16/07 the surveyor requested the patient record for review. The surveyor questioned the AA as to where the SN notes were for after 10/01/07. The AA stated that the record contained all of the notes.</p> <p>On 10/17/07 the surveyor received additional documentation entered into the computerized record by the SN on 10/16/07 indicating:</p>	G 158		

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G 158	<p>Continued From page 43</p> <ul style="list-style-type: none"> <li>- the SN had performed the dressing changes on 09/27/07, 09/28/07, and 10/05/07</li> <li>- the wound center would be changing the dressing on 10/02/07</li> <li>- the caregiver stated by phone on 10/03/07 she would perform the dressing change for the next 2 days as she was instructed at the physician's office.</li> <li>- the patient had been attending the wound center 3 times per week for wound vac therapy/dressing changes</li> </ul> <p>Evidence is lacking the SN:</p> <ul style="list-style-type: none"> <li>- documented the patient's current status until after the surveyor inquired about the missing progresss notes, making the documentation questionable for accuracy</li> <li>- clarified when the wound vac had been initiated</li> <li>- confirmed with the physician SN visits would no longer be needed for wound assessment/dressing changes prior to decreasing the SN visit frequency</li> </ul> <p>This record was reviewed with the AA and AC on 10/18/07 , no additional information was provided.</p> <p>4. Patient #6 was admitted to the agency on 09/28/07. The plan of care included wound care to the bilateral lower extremities to include: wash with soap and water, rinse with tap water, apply antibiotic ointment, wrap in kerlix and ace wrap for five days. On 09/28/07 the SN visited the patient for the initial nursing assessment. It is not clear if the patient or the SN performed the dressing change, as it is documented only that the bilateral lower extremities were wrapped in gauze and an ace bandage. Evidence is lacking the wound was cleansed with soap and water, or antibiotic ointment was applied per the plan of</p>	G 158			

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G 158	<p>Continued From page 44 care.</p> <p>5. Patient #13 was admitted to the agency on 09/07/07 with a primary diagnosis of leg ulcers and secondary diagnoses of edema of the lower extremities. The 09/07/07 plan of care included measurement of edema 2-3 times per week by measuring foot, ankle, mid calf circumference. Although the SN documented at every visit the patient was experiencing continued edema, and discussed with the physician and patient the option of hospitalization for edema control on 10/01/07 and 10/10/07, the SN failed to follow the plan of care and measure for edema 2 - 3 times per week. The measurements were done only on 09/7/07, 09/17/07, 09/28/07, 10/04/07, 10/12/07, 10/22/07.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>6. Patient #14 was admitted to the agency and the Long Term Health Care Program (LTHHCP) on 5/25/07. The 05/25/07 agency plan of care included skilled nursing visits every 2 weeks, however, the Department of Social Services (DSS) summary of required services specified weekly SN visits. Although a home health supervision was done on 06/04/07, and an attempt was made to visit the patient on 07/17/07, evidence is lacking the skilled nurse assessed the patient from 5/25/2007-7/20/2007.</p> <p>Additionally, although the 07/24/07 agency plan of care specified SN assessments 1 time every 2 weeks, the SN assessed the patient's only on 08/16/07, and 09/19/07. Additionally the 09/22/07 agency plan of care specified SN assessments 1</p>	G 158		

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G 158	<p>Continued From page 45</p> <p>- 2 times per week, however the SN only the patient on 09/22/07 and 10/13/07.</p> <p>Visits for 09/07/07 and 10/04/07 were documented in the patient record as late entries on 10/31/07. Evidence was lacking this documentation was entered into the record prior to the surveyor requesting it on 10/31/07, making the accuracy of these entries questionable.</p> <p>7. Patient #17 was admitted to the agency's LTHHCP on 06/10/05. The 07/30/07 and 09/28/07 485's and 04/13/07 and 08/13/07 DSS summary of required services included SN visits every month. Evidence is lacking the SN visited the patient from 08/01/07 - 09/26/07.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>8. Patient #22 was admitted to the agency's LTHHCP on 12/11/06. The DSS summary of required services specified HHA/PCA service 15 hours per week, however, from 08/12/07 - 10/05/07 the patient received only 13 hours of aide service per week.</p> <p>Evidence is lacking the agency made adequate recruitment efforts to ensure aide service was available for all patients per the plan of care. Specifically, the AA provided the surveyor with documentation of their aide recruitment efforts. Evidence is lacking the agency made any recruitment efforts for Home Health Aides (HHA) since March 2007, or made any recruitment efforts for candidates for Home Health Aide training. Specifically, the AA told the surveyor they</p>	G 158			

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G 158	Continued From page 46 had not conducted a HHA training program since July 2003.  This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.  9. Patient #16, was admitted to the agency on 03/07/07. The 04/13/07 - 08/13/07 and 08/13/07 - 12/13/07 DSS summary of required services included monthly SN visits, and the 07/05/07 agency plan of care specified SN visits every other week. Evidence is lacking that any SN visits were made after 07/25/07. Following the surveyors review of the record on 11/27/07, the SN submitted documentation for visits made on 08/16/07 and 08/22/07. The computer indicated both notes were submitted on 11/27/07. Evidence was lacking these SN visits occurred prior to the surveyor requesting the patient record on 11/27/07, making the accuracy and authenticity of these entries questionable.	G 158	<b>G159 PLAN OF CARE</b>  <b>Policies and procedures will be of sufficient scope</b> to ensure development of a plan of care that is comprehensive, individualized, which includes specific interventions to adequately assess and treat a patient's conditions and symptoms and addresses, but is not limited to the following: 1) all pertinent diagnoses including mental status, 2) types of services and visit frequency, 3) equipment required including vendor contact information, 4) prognosis, 5) rehabilitation potential, 6) functional limitations, 7) activities permitted, 8) nutritional requirements, 9) medications, 10) treatments, 11) safety measures, 12) instructions for		
G 159	<b>484.18(a) PLAN OF CARE</b>  The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.  This STANDARD is not met as evidenced by: Based on a review of 22 clinical records, and 5 observational home visits, and interviews with the	G 159	timely referral or discharge, 13) or other items as appropriate.  The DPS and/or Designee will review and or revise where appropriate policies and procedures related development of a plan of care by <b>01/08/08</b> . The DPS and or AA will present the revised policies and procedures to the Professional Advisory Committee (PAC) by <b>01/09/08</b> for review and approval and to the Governing Authority for review and approval by <b>01/10/08</b> .	1/08/08 4/9/08 1/10/08	

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G 159	<p>Continued From page 47</p> <p>Agency Administrator (AA), Director of Nursing (DON) and Agency Consultant, evidence is lacking in 8 records the plan of care developed is of sufficient scope to meet the patient's needs. Patients # 1, 4, 5, 6, 7, 10, 12, 15</p> <p>Lack of a complete and accurate plan of care has the potential for unmet patient needs and possible negative patient outcomes.</p> <p>Examples are as follows:</p> <p>1. 6 patient records contain duplicate medication orders which are inconsistent, making it difficult to determine the correct medication dose. Patient # 1, 5, 6, 7, 12, 15</p> <p>Examples are as follows: HV - Patient #5 was admitted to the agency on 10/08/07. The plan of care failed to include an accurate medication plan as follows: The 10/08/07 plan of care included vancomycin 10 gm every 12 hours intravenously (IV), however, the plan also included vancomycin IV (no dose) every 24 hours, and the verbal orders obtained on 10/09/07 specified vancomycin 1 gm IV every 24 hours. On 10/22/07 the surveyor made an observational home visit with the Skilled Nurse (SN). The IV medication bag indicated the vancomycin dose was 1 gram in 200cc dextrose to infuse over an hour which was being infused once daily. Evidence is lacking the plan of care included the accurate dose of vancomycin, or complete orders for the IV infusion. Additionally the surveyor observed the primary caregiver was flushing the peripherally inserted central catheter (PICC) line with 5cc normal</p>	G 159	<p>Patients #1, #4, #6, #10, #12, #13 identified under this standard are no longer on service; Patients #5 and #7 remain on service, but no longer have a vascular access device or subcutaneous catheter; an example for patient #15 was not included. Patient #15 remains on service and a thorough review will be completed to ensure that assessment data is current, accurate, and sufficient in scope to ensure development of a care plan that meets the patient's needs by 01/03/08).</p> <p>The policies and procedures will address, but not be limited to areas identified to be deficient in the 12/19/07 SOD issued to the agency by NYSDOH as indicated below:</p> <ul style="list-style-type: none"> <li>Medication reconciliation with the patient, physician, and pharmacy supplier to ensure accurate dose, frequency, and route (if use of sub cutaneous catheter is indicated, that must be specified) (patients #1, #4, #5, #6, #7, #10, #12 no longer on service) (patients #5 and #7 no longer have vascular access devices or subq catheters)</li> <li>Care of Vascular Access Devices and administration of medications via these devices (patients #5 and #7 no longer have vascular access devices or subq catheters)</li> <li>Complete and accurate care plan for patients with wounds, pain, tracheostomy, and gastrostomy care/feedings to include assessment</li> </ul>	y3/08	

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G 159	<p>Continued From page 48</p> <p>saline before and after administration of the vancomycin per the hospital instructions, however, the plan of care indicated the PICC was to be flushed with 10cc normal saline. The record was reviewed on 11/13/07 with the agency administrator and agency consultant. The surveyor questioned if the plans of care are reviewed prior to being sent to the physician. The administrator stated all plans of care are reviewed by herself or a nursing supervisor. This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>HV</p> <p>- Patient #7 was a [REDACTED] admitted to the agency on 10/24/07 with a primary diagnosis of Burkitts Tumor (lymphoma), and secondary diagnosis of vascular access device. The plan of care failed to include a complete and accurate medication plan as follows:</p> <p>On 10/24/07 a verbal order was obtained from the physician by the SN which included neupogen via subcutaneous catheter daily. The plan of care, however, only included neupogen subcutaneously, and failed to specify the medication was to be administered via the subcutaneous catheter.</p> <p>On 10/24/07 an observational home visit was made by the surveyor with the SN for the initial nursing assessment. The surveyor observed the neupogen label specified the medication was to be given for 12 days, however, the plan of care failed to include this, and the SN failed to clarify this with the physician.</p> <p>Additionally, the plan of care included</p>	G 159	<p>and management (patients #4, #6 no longer on service)</p> <p><b>Evaluation of comprehensive care planning on a concurrent basis:</b></p> <ul style="list-style-type: none"> <li>The case manager will forward to the DPS or Designee assessments and plans of care completed on all patients at three points in time; 1) start of care, 2) resumption of care, and 3) recertification within 24 hours of the completion of the assessment visit.</li> <li>The DPS or Designee will audit the assessment data to ensure completeness and accuracy and the plan of care to ensure that it is comprehensive, accurate, and addresses patient needs. The audit will be completed within 24 hours of receipt of the completed assessment and plan of care. The current audit tool and quality indicators are under revision and will address, but not be limited to areas identified to be deficient in the past and most recent DOH surveys. The audits will be completed on 100% of the patient's on each case manager's roster at all three points in time. When a case manager reaches a 90% compliance rate with the quality indicators the audits for that case manager will decrease to 50% audit of the case manager's patient roster at all three points in time. If at any time the case manager's compliance rate drops below 90%, audit frequency will</li> </ul>	12/10/08

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G 159	<p>Continued From page 49</p> <p>contradictory instructions for PICC line maintenance. Specifically, the plan of care included heparin lock flush once daily intravenously, however also included every Tuesday and Friday.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>- Patient #12 was admitted to the agency on 10/29/07. The plan of care failed to include complete and accurate medications, and included conflicting frequencies for sinemet (anti parkinsonian). The plan of care, and 10/29/07 verbal orders specified sinemet 10/200 mg 1/2 tablet every one and a half-hours between 06:30 and 17:30, however, the plan also specified sinemet 10/200 mg 1/2 tablet once daily.</p> <p>The record was reviewed with the AA and the DON on 11/13/2007, no further information was provided.</p> <p>2. Patient #6 was admitted to the agency on 09/28/07 with a primary diagnosis of lower extremity cellulitis and secondary diagnoses of head and neck cancer and post radical neck dissection. The patient also had a gastrostomy tube for medications and tube feedings. The plan of care failed to include the following:</p> <p>-accurate medication plan. Specifically, the 09/28/07 initial nursing assessment and 09/28/07 verbal order from the physician included augmentin 400 mg twice daily for one week, however, the 09/28/07 plan of care included augmentin 400mg once daily.</p>	G 159	<p>return to 100%. If the DPS or Designee identifies deficiencies through the audit, the deficiencies will either be corrected at the time of the review or a plan to correct the deficiencies will be developed. The nurse who completed the assessment/plan of care will follow up with the DPS or Designee within an agreed upon timeframe based on urgency of the corrective action to be taken. The DPS or Designee will flag the audit tool for follow up, and if contact by the nurse has not occurred reporting corrective action the DPS or Designee will contact the nurse to</p> <p>discuss the outcome of the planned corrective action.</p> <ul style="list-style-type: none"> <li>The DPS or Designee will maintain the results of assessment and care plan audits by patient in a notebook that will be labeled Patient Case Conference/Audits. This notebook will be maintained in the DPS office. After the patient is discharged from the agency the DPS or Designee will remove the patient specific case audits from the notebook and request that support staff file them by month of discharge alphabetically in a cabinet in the locked medical record room.</li> <li>The DPS or Designee will trend the results of these audits by individual and by group on a monthly basis or sooner based on results of data (weekly at present).</li> </ul>	<p>1/15/08</p> <p>1/15/08</p>	



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NAME OF PROVIDER OR SUPPLIER

**VNS ITHACA TOMPKINS CO CHHA**

STREET ADDRESS, CITY, STATE, ZIP CODE

**138 CECIL A MALONE DRIVE  
ITHACA, NY 14850**

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G 159	<p>Continued From page 50</p> <p>-complete and accurate wound care plan. Specifically, the 09/28/07 initial nursing assessment included dressings to the right and left mandible, however the 09/28/07 verbal orders from the physician indicated dressing changes to left mandible only, and the plan of care indicated dressings to the right mandible only.</p> <p>Additionally, the plan of care included wound care to the bilateral lower extremities to include wash with soap and water, rinse with tap water, apply antibiotic ointment, wrap in kerlix and ace wrap for five days. The plan of care, however, failed to specify the frequency of the dressing change, or the type of antibiotic ointment.</p> <p>-complete and accurate plan for pain control. Specifically, the 09/28/07 plan of care included oxycontin (narcotic analgesic) 200 mg twice daily as needed for pain, however, verbal orders included oxycontin (narcotic analgesic) 200 mg twice daily for pain relief, and did not indicate the medication was to be used as needed.</p> <p>- complete and accurate plan for tracheostomy care. Specifically, the plan failed to include: a plan to assess the patient's respiratory status or tracheostomy secretions; if the patient required suctioning; if suctioning equipment was available in the home if needed.</p> <p>- complete and accurate plan for gastric tube. Specifically, the 09/28/07 verbal orders indicated the gastric tube is to be flushed with 2 cc of water before and after administration of the augmentin, however, the 09/28/07 plan of care failed to include this.</p>	G 159	<ul style="list-style-type: none"> <li>The DPS and or Designee will meet with the AA on a monthly basis (1<sup>st</sup> Tuesday of each month) or more frequently if compliance rates are below 90% (weekly at present) to discuss and analyze the results of the audits. Areas identified to be in need of improvement will be identified and corrective action plans will be developed, implemented and monitored. Corrective actions planned may be by group or by individual.</li> <li>The DPS or Designee will provide the agency Human Resources Designee with a copy of individual audit trending results for filing in that individuals personnel file for use in staff development and performance evaluations.</li> <li>The DPS or Designee will provide the PAC and Governing Authority with the trended case management audit results and individual audit findings quarterly or sooner based on results for review and action.</li> </ul> <p><b>Evaluation of comprehensive care planning on a retrospective basis is incorporated into the 2 to 4 week record review process and the quarterly clinical record review process (see G250).</b></p>	<p>1/15/08</p> <p>1/15/08</p> <p>1/15/08</p> <p>1/15/08</p>

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G 159	Continued From page 51 -Clear plans for frequency of nursing visits. Specifically, the 09/28/07 verbal orders indicated that the patient is to be visited by nursing once daily for 2 days, once daily for 1 day, then 4 visits daily for 7 days. The plan of care states that the patient should receive skilled nursing visits twice daily for 2 days, 4 times in seven days for 7 days, 1-2 times per week for 4 weeks.  3. Patient # 4 was admitted to the agency on 09/26/07 with a primary diagnosis of uncontrolled diabetes, and secondary diagnosis of foot ulcer. Evidence is lacking the plan of care included the following: - the patient was checking finger stick blood sugars twice daily with reporting parameters to the physician of less than 60 or greater than 200 per the initial nursing assessment - had bilateral positive airway pressure (BIPAP) at night per the initial nursing assessment - a plan to assess the wound. Specifically, evidence is lacking the SN ever measured the wound following the initial nursing assessment on 09/26/07.  This record was reviewed with the AA and AC on 10/18/07, no additional information was provided.	G 159	The DPS and or Designee will present an in-service on the revised assessment and care plan development policies and procedures and related practice standards to staff by 01/10/08. Focus areas will include, but not be limited to medication reconciliation, wounds, pain, tracheostomies, and gastrostomyies with follow up in-service for those required to attend that did not by 01/14/08 The revised policies and procedures will be implemented 01/15/08  <b>G 164 PERIODIC REVIEW OF PLAN OF CARE</b>  <b>Policies and procedures will be of sufficient scope</b> to ensure 1) that if a physician refers a patient under a plan of care that cannot be completed until after the initial evaluation, the nurse contacts the physician to approve additions or modifications to that plan and 2) that the physician is informed of changes in the patient's condition which suggest a need to alter the plan of care. (#1 addresses G 160 which was identified under G 156, but not specifically addressed)  The DPS and/or Designee will review and or revise where appropriate policies and procedures related to physician communication by 01/08/08. The DPS and or AA will present the revised policies and procedures to the Professional Advisory Committee (PAC) by 01/09/08 for review and approval and to the Governing Authority for review and approval by 01/10/08.	1/10/08  1/14/08 1/15/08	
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE  Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.  This STANDARD is not met as evidenced by: Based on a review of 22 clinical records and 5 observational home visits, and interviews with the Agency Administrator (AA), Director of Nursing	G 164		1/8/08  1/9/08	

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G 164	<p>Continued From page 52</p> <p>(DON), and Agency Consultant, evidence is lacking in 3 records the physician is consulted when changes in the patients's condition occurs. Patients # 1, 6, 13</p> <p>Failure to report a change in the patient's condition resulted in a negative outcome for patient # 1 and 13, and has the potential for agency wide unmet patient needs, and possible negative patient outcomes.</p> <p>Evidence is as follows:</p> <p>1. Patient #13 was admitted to the agency on 09/07/07 with a primary diagnosis of left lower leg ulceration. The plan of care included daily dressing changes by the Skilled Nurse (SN), and on 09/13/07 was updated with the physician to continue daily dressing changes by the SN. The initial nursing assessment indicated the patient was referred by the wound center because maggots had been identified in the patient's wound, however, this had been resolved.</p> <p>On 09/23/07 the SN visited the patient and documented several small maggots were observed between the patient's toes. Evidence is lacking the patient had any maggot infestation since admission to the agency on 09/07/07, or that this change in condition was reported to the physician.</p> <p>Evidence was lacking a SN visit was made on 09/24/07 per the plan of care, however on 10/23/07, following the receipt of the patient record by the surveyor for review, the SN handed the surveyor hand written visit notes dated 09/24/07 labeled as a late entry on 10/23/07. The note included the presence of several small</p>	G 164	<p>Patients identified under this standard are no longer on service; therefore, there is no patient specific corrective action (Patients #1, #6, #13).</p> <p>The policies and procedures will address, but not be limited to areas identified to be deficient in the <b>12/19/07</b> SOD issued to the agency by NYSDOH as indicated below:</p> <ol style="list-style-type: none"> <li>1) Physician contact, discussion, and approval via telephone or FAX regarding the need to make additions or modifications to the plan of care after the initial evaluation or at any time with follow up in writing</li> <li>2) Maintenance of accurate baseline and current clinical assessment data in the clinical record by all professional staff responsible for developing and implementing the plan of care and case conference notes to be used to assist in identifying changes in patient status and guide the action plan</li> <li>3) Thorough assessment of all suspected or reported changes in the patient's clinical status with complete and accurate documentation in the clinical record by the professional assessing the patient to include, but not be limited to wound status, weight loss, and nutrition (patients #13, #2, #6 no longer on service)</li> </ol>		

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G 164	<p>Continued From page 53</p> <p>maggots between the patient's toes. Evidence is lacking: the SN reported the maggot infestation to the physician. Additionally, the accuracy and authenticity of the 09/24/07 documentation is questionable as it was not submitted until one month following the visit.</p> <p>On 09/25/07 the SN visited the patient and the patient stated "I had an awful time last night, I couldn't sleep and my left foot was bothering me. I removed part of the dressing and I had hundreds of maggots on my foot. It was terrible. I cleaned it as best I could" The SN removed the dressing from the left leg and documented the entire leg was covered with white maggots. The SN sent the patient to the emergency room.</p> <p>Failure of the SN to report to the physician on 09/23/07 and 09/24/07 that the patient's wound was infested with maggots to the physician resulted in unnecessary discomfort, resulting in a delay of treatment of the maggots.</p> <p>On 11/14/07 the surveyor interviewed the SN, and questioned the SN as to why he did not report the maggots on 09/23/07, and 09/24/07. The SN was unable to explain why, and stated he thought the patient had a problem with maggots all along. The SN was also unable to explain why the 09/24/07 SN progress note was "missing" from the patient's chart.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>2. Patient #1 was admitted to the home care agency on 9/11/2007 with secondary diagnoses of type 2 diabetes mellitus and nausea and</p>	G 164	<p>4) Reporting of assessment data based on established parameters in the plan of care such as, but not limited to weight loss (patients #2, #6 no longer on service)</p> <p>5) Reporting of changes identified in the patient's condition by the assessor to the physician at the time the changes are identified with revision to the plan of care, as needed. Based on professional nursing standards, some identified changes in patient condition may require immediate emergency department referral with physician notification to follow (Patient #13 sent to emergency department with no evidence physician was notified). Data specifically reported to the physician by the professional will be complete and documented in the clinical record as being reported to the physician. The professional will follow up by completing a clinical summary form documenting the information reported to the physician and directing support staff to fax the form to the physician for signature (interim orders to be obtained if physician has directed changes to the plan of care). If the professional is unable to reach the physician by telephone he/she will continue their efforts, as well as fax a clinical summary to the physician. If the physician does not respond in a timely matter, based on individual situation, the professional will consult the DPS for further direction.</p>		

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G 164	<p>Continued From page 54</p> <p>vomiting. The plan of care included zofran 8 mg every four hours for nausea and vomiting. The 09/11/07 initial nursing assessment indicated the patient's weight was 155 pounds. Evidence is lacking that the following changes in patient condition were reported to the physician:</p> <ul style="list-style-type: none"> <li>- On 10/02/07 the SN documented: the patient's weight was 145 pounds, evidence is lacking the SN reported the 10 pound weight loss to the physician. Additionally evidence is lacking the SN reported the patient had decreased appetite; was not drinking well; vomited a large amount of emesis per her assessment.</li> <li>- On 10/09/07 the SN documented the patient's weight was 145.5 pounds, and the patient had complaints of intermittent nausea and dry heaves.</li> </ul> <p>Evidence is lacking the SN: reported the patient's weight loss, or nausea and vomiting to the physician until the patient was discharged from the agency on 10/30/07.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>3. Patient #6 was admitted to the agency on 09/28/07 with a secondary diagnosis of head and neck cancer. The plan of care included: gastric tube feedings of jevity 4 times per day; 50ml of water before and after feedings; and wash gastric tube site daily and apply dry dressing.</p> <p>On 10/18/07 the SN visited and discharged the patient. Although the SNs documented the patient weighed 152 pounds on 09/28/07 and 139 pounds on 10/18/07, and the patient's appetite</p>	G 164	<p>The AA will send a letter to physicians in the community and to those known to refer patients to the agency by <b>1/15/08</b> encouraging enhanced communication with agency staff and to solicit strategies for improving and streamlining communication to promote quality patient care.</p> <p>The DPS and or Designee will present an in-service on the policies and procedures related to 1) the role and responsibility of the nurse to inform the physician of changes in the patient's condition which suggests a need to alter the plan of care and 2) that states that if a physician refers a patient under a plan of care that cannot be completed until after the initial evaluation the nurse will contact the physician to approve additions or modifications to that plan by <b>01/10/08</b> with follow up in-service for those required to attend that did not by <b>01/14/05</b>. The revised policies and procedures will be implemented <b>01/15/08</b></p> <p><b>Evaluation of communication with the physician on a concurrent basis:</b></p> <p>The DPS and or Designee will assess compliance with the above on a concurrent basis through start of care, restart of care, and recertification and case management audits and case conferences by <b>01/15/08</b> (see G143)</p>	<p>1/15/08</p> <p>1/10/08</p> <p>1/14/08</p> <p>1/15/08</p> <p>1/15/08</p>

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G 171	<p>Continued From page 56 NURSE</p> <p>The registered nurse makes the initial evaluation visit.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 15 clinical records, 5 observational home visits, and interviews with the Agency Administrator (AA), Director of Nursing (DON), and Agency Consultant, evidence is lacking in 8 records the initial nursing assessments are of sufficient scope to ensure that all patient needs are met. Patients # 1, 6, 7, 10, 11, 12, 13, 15</p> <p>Lack of complete and accurate nursing assessments has the potential for unmet patient needs and possible negative patient outcomes.</p> <p>Examples are as follows:</p> <p>HV</p> <p>1. Patient #7 was a [REDACTED] male admitted to the agency on 10/24/07 with a primary diagnosis of Burkitts Tumor (lymphoma), and secondary diagnosis of vascular access device. The initial nursing assessment failed to include:</p> <ul style="list-style-type: none"> <li>- complete and accurate assessment of the subcutaneous catheter site. Specifically, although the Skilled Nurse (SN) removed the catheter which had become dislodged, and reinserted it later that day, the SN failed to document an assessment of the site.</li> <li>- complete and accurate assessment of the hickman catheter. Specifically, on 10/24/07 the surveyor conducted a home visit with the SN. The</li> </ul>	G 171	<p><b>G171 DUTIES of the REGISTERED NURSE</b></p> <p>Policies and procedures will be of sufficient scope so that initial nurse assessments are accurate and complete baseline data is obtained so that patient needs can be met.</p> <p>The DPS and/or Designee will review and or revise where appropriate policies and procedures related to initial nurse assessment by 01/08/08. The DPS and or AA will present the revised policies and procedures to the Professional Advisory Committee (PAC) by 01/09/08 for review and approval and to the Governing</p> <p>Authority for review and approval by 01/10/08.</p> <p>Patients #1, #6, #7, #10, #11, #12, #13 identified under this standard are no longer on service; Examples for patients #12, #13, #15 were not included under this standard; Patient #15 remains on service and a thorough review will be completed to ensure that assessment data is current, accurate, and sufficient in scope to ensure development of a care plan that meets the patient's needs by 01/03/08).</p> <p>The policies and procedures will address, but not be limited to areas identified to be deficient in the 12/19/07 SOD issued to the agency by NYSDOH as indicated below:</p>	<p>1/8/08</p> <p>1/9/08</p> <p>1/10/08</p> <p>1/3/08</p>	



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G 171	<p>Continued From page 57</p> <p>SN failed to assess the hickman catheter site, or if the dressing was intact.</p> <p>Additionally, although the plan of care indicated the hickman catheter was to be flushed daily, and also every Tuesday and Friday, the SN documented the next SN visit was not scheduled until 9 days later on 11/02/07. The SN failed to document the patient was to be seen by the physician for the flush and dressing change in the interim, as discussed with the patient's mother during the initial assessment.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>2. Patient #11 was admitted to the agency on 05/03/07 with a secondary diagnosis of obsessive compulsive disorder. The plan of care included weekly assessments of the patient's emotional status, including anxiety, depression, anger. The initial nursing assessment indicated the patient: was delusional, hallucinatory; exhibiting paranoid behaviors; was very anxious; and would not allow the SN past his foyer. The SN failed to:</p> <ul style="list-style-type: none"> <li>- report the patient's psycho social status to the physician</li> <li>- assess for the possible need of a social work referral</li> <li>- plan to reassess the patient's psycho social status until 1 week later</li> </ul> <p>The record was reviewed with the AA and the DON on 11/13/2007. No additional information was provided.</p>	G 171	<ul style="list-style-type: none"> <li>• Complete, clear, and accurate description of edema, wounds, ostomy sites, subcutaneous catheter sites, and vascular access device sites (patients #6, #7, #10, #1 no longer on service)</li> <li>• Thorough assessment of patient and or primary caregiver's ability and willingness to participate in care plan development to include sufficient detail related to roles and responsibilities in that plan.</li> <li>• Competency determinations by agency nurses based on observation of patient and or primary care giver performing procedures such as care of wounds, vascular access devices, ostomies, tube feedings, and fingerstick blood sugars (patient #6, #10, #1 no longer on service)</li> <li>• Accurate assessment of nursing visit frequency needs to ensure that objectives of the plan can be met with immediate communication with the physician if all or any part of the nursing assessment cannot be completed within the timeframe specified by the physician (#11 no longer on service) (no back dating of physician orders to cover frequency of visits completed as opposed to frequency ordered (patient #11 no longer on service)</li> <li>• Complete, accurate assessment of emotional status to include anxiety, anger, depression (#11 no longer on service).</li> </ul>		



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G 171	<p>Continued From page 58</p> <p>3. Patient #6 was admitted to the agency on 9/28/2007 with a primary diagnosis of bilateral lower extremity cellulitis and open wounds. The patient had secondary diagnoses of radical neck dissection for head and neck cancer. The initial nursing assessment identified: 4 locations of open wounds and labeled them 1 through 4; the patient had a tracheostomy and percutaneous endoscopic gastrostomy (PEG) tube. Evidence is lacking the initial nursing assessment was accurate and complete as follows:</p> <p>- complete and accurate wound assessment. Specifically, wound #1 location was described as bilateral lower extremity (BLE), however, the SN failed to: assess for wound drainage; describe the specific wound location/s or measure the wound/s. Specifically the wound measurements were documented as "PEG".</p> <p>Additionally, although the SN documented the patient was "deemed competent in wound care", evidence is lacking the SN observed the patient performing the dressing change.</p> <p>Wound #4 location was identified as BLE, however, the description was of the patient's mandible wound.</p> <p>- complete and accurate medication assessment. Specifically, the plan of care included: oxycodone and oxycontin (narcotic analgesics) which are known to cause constipation; docusate 100 mg five times daily for constipation; senna 8.6 mg as needed for constipation. Evidence is lacking the skilled nurse assessed: the patient's last bowel movement; if the patient was taking the docusate per the plan of care; if the patient was taking the as needed senna.</p>	G 171	<p>The DPS and or Designee will present an in-service on the <i>revised assessment policies and procedures</i> to staff by <b>01/10/08</b>. The revised policies and procedures will be implemented by <b>01/15/08</b>.</p> <p>The DPS and or Designee will present an in service to staff on completion of thorough, accurate initial nursing assessments and OASIS data set completion by <b>01/15/08</b>.</p> <p>The DPS and or Designee will arrange for an in service related to care of vascular access devices and administration of medications intravenously or via subcutaneous by <b>02/15/08</b>. Policies and procedures related to the above will be reviewed, revised and or developed and approved by PAC and the Governing Authority by <b>2/15/08</b>. The agency will not admit patient's requiring these services until the in service has been provided and staff have attended and been observed by the DPS and or Designee to be competent in the procedure.</p> <p><b>Evaluation of comprehensive nursing assessment on a concurrent basis:</b></p> <ul style="list-style-type: none"> <li>The case manager will forward to the DPS or Designee assessments and plans of care completed on all patients at three points in time; 1) start of care, 2) resumption of care, and 3) recertification within 24 hours of the completion of the assessment visit.</li> </ul>	<p>1/10/08 1/15/08</p> <p>1/15/08</p> <p>2/15/08</p> <p>2/15/08</p> <p>1/15/08</p>	

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G 171	<p>Continued From page 59</p> <p>- complete and accurate tracheostomy assessment. Although the nurse documented the tracheostomy site was healed, and had a dressing on it, the SN also documented the patient denied any secretions via the tracheostomy, indicating the tracheostomy was functioning as the patient's airway. Evidence is lacking the SN: assessed the site; assessed if the patient required suctioning; and if so, if the patient had suction equipment in the home; clarified with the physician what the tracheostomy care included; observed the patient performing tracheostomy care. Specifically, the SN documented she was unable to measure the tracheostomy site because the patient had completed the tracheostomy care prior to her arrival.</p> <p>- complete and accurate gastric tube assessment. Specifically, the SN documented the patient utilized a gastric tube for feedings, and the gastric tube site had a dressing on it. Evidence is lacking the SN: observed the patient administering the tube feedings or flushing the PEG tube; or clarified with the physician what the PEG tube care included. Specifically, the SN documented she was unable to measure the PEG tube site at the patient's request because the patient had completed the care to PEG tube site prior to her arrival.</p> <p>4. Patient #10 was admitted to the agency on 09/19/07. The plan of care indicated the SN was to make weekly visits for assessment of right buttocks pressure ulcer, and assess flap. The plan also included: teaching the patient to wash scabbed abrasions and skin flap with soap and</p>	G 171	<ul style="list-style-type: none"> <li>The DPS or Designee will audit the assessment data to ensure completeness and accuracy and the plan of care to ensure that it is comprehensive, accurate, and addresses patient needs. The audit will be completed within 24 hours of receipt of the completed assessment and plan of care. The current audit tool and quality indicators are under revision and will address, but not be limited to areas identified to be deficient in the past and most recent DOH surveys. The audits will be completed on 100% of the patient's on each case manager's roster at all three points in time. When a case manager reaches a 90% compliance rate with the quality indicators the audits for that case manager will decrease to 50% audit of the case manager's patient roster at all three points in time. If at any time the case manager's compliance rate drops below 90%, audit frequency will return to 100%. If the DPS or Designee identifies deficiencies through the audit, the deficiencies will either be corrected at the time of the review or a plan to correct the deficiencies will be developed. The nurse who completed the assessment/plan of care will follow up with the DPS or Designee within an agreed upon timeframe based on urgency of the corrective action to be taken. The DPS or Designee will flag the audit tool for follow up, and if contact by the nurse has not occurred reporting corrective action the DPS or Designee will contact the nurse to discuss the outcome of the planned corrective action.</li> </ul>	1/15/08	

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G 171	<p>Continued From page 60</p> <p>water every day, and to use a mirror to assess any open areas. The 09/19/07 initial nursing assessment indicated the patient had 3 ischial wounds, however, the assessment was incomplete as follows:</p> <ul style="list-style-type: none"> <li>- the SN documented the patient had 3 decubitus wounds on her right ischium, however, there was no further delineation of the location of the wounds, therefore making accurate comparison of follow up measurements impossible</li> <li>- although the SN documented the patient was competent in wound care by the wound center, evidence is lacking the SN observed the patient performing the wound care, and did not visit the patient again until 8 days later on 09/27/07. Additionally, evidence is lacking the patient was able to observe the wounds with a mirror per the plan of care.</li> </ul> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>5. Patient #1 was admitted to the agency on 9/11/2007 with a secondary diagnosis of diabetes. The plan of care included: a peripherally inserted central catheter (PICC) line for intravenous (IV) antibiotic administration; daily blood glucose monitoring; novolin 70/30 insulin subcutaneously 5 units every AM, which was listed as a new medication. Evidence is lacking the SN:</p> <ul style="list-style-type: none"> <li>- observed the primary caregiver (PCG) performing the finger stick blood sugars</li> <li>- observed if the PCG was able to correctly use the glucometer</li> <li>- determined if there was a glucometer in the patient's home</li> </ul>	G 171	<ul style="list-style-type: none"> <li>• The DPS or Designee will maintain the results of assessment and care plan audits by patient in a notebook that will be labeled Patient Case Conference/Audits. This notebook will be maintained in the DPS office. After the patient is discharged from the agency the DPS or Designee will remove the patient specific case audits from the notebook and request that support staff file them by month of discharge alphabetically in a cabinet in the locked medical record room.</li> <li>• The DPS or Designee will trend the results of these audits by individual and by group on a monthly basis or sooner based on results of data (weekly at present). <ul style="list-style-type: none"> <li>• The DPS and or Designee will meet with the AA on a monthly basis (1<sup>st</sup> Tuesday of each month) or more frequently if compliance rates are below 90% (weekly at present) to discuss and analyze the results of the audits. Areas identified to be in need of improvement will be identified and corrective action plans will be developed, implemented and monitored. Corrective actions planned may be by group or by individual.</li> </ul> </li> <li>• The DPS or Designee will provide the agency Human Resources Designee with a copy of individual audit trending results for filing in that individuals personnel file for use in staff development and performance evaluations.</li> </ul>	1/15/08

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G 172	<p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p><b>484.30(a) DUTIES OF THE REGISTERED NURSE</b></p> <p>The registered nurse regularly re-evaluates the patients nursing needs.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 15 clinical records, 5 observational home visits, and interviews with the Agency Administrator (AA), Director of Nursing (DON), and Agency Consultant (AC), evidence is lacking in 7 records the skilled nursing (SN) reassessments are of sufficient scope to identify changes in the patient's condition which may require re-evaluation and/or modification in the plan of care. Patients # 1, 2, 4, 6, 10, 11, 13</p> <p>Failure to perform complete and accurate nursing assessments resulted in a negative outcome for patient # 2, 6, 11, and has the potential for agency wide unmet patient needs, and possible negative patient outcomes.</p> <p>1. Patient #11 was admitted to the agency on 05/03/07 with a secondary diagnosis of obsessive compulsive disorder. The plan of care specified weekly Skilled Nurse (SN) visits to assess the patient's emotional status, including anxiety, depression, anger. The Skilled Nursing (SN) reassessments were incomplete as follows:</p> <p>- On 05/17/07 the SN visited the patient, and documented the patient did not allow the SN past the front hallway. Evidence is lacking the SN</p>	G 172	<ul style="list-style-type: none"> <li>The DPS or Designee will provide the PAC and Governing Authority with the trended case management audit results and individual audit findings quarterly or sooner based on results for review and action.</li> </ul> <p><b>Evaluation of comprehensive nursing assessment on a retrospective basis is incorporated into the 2 to 4 week record review process and the quarterly clinical record review process (see 350).</b></p> <p><b>G172 DUTIES of the REGISTERED NURSE</b></p> <p><b>Policies and procedures will be of sufficient scope</b> to ensure that nurse reassessments are sufficient in scope so that accurate and complete baseline data is obtained so that patient needs can be met.</p> <p>The DPS and/or Designee will review and or revise where appropriate policies and procedures to ensure that the nurse regularly reevaluates the patient's needs in sufficient detail so that accurate and complete data is obtained so that patient needs can be met by <b>01/08/08</b>. The DPS and or AA will present the revised policies and procedures to the Professional Advisory Committee (PAC) by <b>01/09/08</b> for review and approval and to the Governing Authority for review and approval by <b>01/10/08</b>.</p>	<p>11/15/08</p> <p>1/8/08</p> <p>1/9/08</p> <p>1/10/08</p>

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G 172	<p>Continued From page 62</p> <p>assessed the patient's emotional status during this visit, or ever reassessed his emotional status.</p> <p>- On 06/05/07 the SN attempted to visit the patient, however, the wife reported that she was unwilling to accept a visit because they were moving soon. Evidence is lacking the SN reported to the physician the SN was unable to visit the patient, or that the patient's emotional status had not been assessed since admission on 05/03/07.</p> <p>- On 06/07/07 the SN documented the patient was admitted to the hospital for an apparent suicide attempt. This was confirmed by the patient's hospital record.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>2. Patient # 2 was admitted to the agency on 06/06/07 with a primary diagnosis of urinary tract infection, and secondary diagnoses of dehydration, mental disorder, difficulty walking. The patient was receiving aide service from a Licensed Home Care Services Agency which was being paid for privately by the patient's son. The initial assessment indicated the patient was unable to use her personal emergency response system due to dementia. The skilled nursing reassessments were inaccurate or incomplete as follows:</p> <p>On 06/07/07 the SN documented the patient was experiencing acute diarrhea. Evidence is lacking the SN assessed if the patient was continuing to take colace (bowel medication) twice daily and metamucil (bowel medication) every other day per the plan of care. The physician directed the</p>	G 172	<p>Patients #1, #2, #4, #6, #10, #11, #13 identified under this standard are no longer on service.</p> <p>The policies and procedures will address, but not be limited to areas identified to be deficient in the <b>12/19/07</b> SOD issued to the agency by NYSDOH as indicated below:</p> <ul style="list-style-type: none"> <li>• Complete, clear, and accurate description of edema, wounds, ostomy sites, subcutaneous catheter sites, and vascular access device sites (patients #6, #10, #1 no longer on service)</li> <li>• Competency determinations by agency nurses based on observation of patient and or primary care giver performing procedures such as care of wounds or tube feedings (Patients #4, #6 no longer on service)</li> <li>• Complete, accurate assessment of nutrition status to include specific nutrition requirements, related teaching, assessment for compliance, weight assessment, and communication with the physician with changes in the patient's condition that suggest a need to alter the plan of care (patients #1, #6 no longer on service)</li> <li>• Criteria for referral to other disciplines such as nutrition (patients #1, #6 no longer on service) or social work (#11 no longer on service).</li> <li>• Reporting of assessment data to the physician that falls into the parameters specified on the plan such as weight loss/gain (patients #1, #6 no longer on service)</li> </ul>		1/15/08

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G 172	<p>Continued From page 63</p> <p>patient to the emergency room, however, evidence is lacking the patient ever went to the emergency room, or that the SN reassessed the patient until 4 days later on 06/11/07.</p> <p>On 06/11/07 the SN visited the patient, however, evidence is lacking the SN assessed the patient's bowel status. Specifically, the SN failed to assess the status of the diarrhea or bowel frequency, or if the patient was continuing to take colace and metamucil per the plan of care.</p> <p>Additionally, the SN instructed the aide to give imodium after each loose stool. Although it is not within the scope of tasks for a Home Health Aide (HHA) to administer medications to a non self directed patient, evidence is lacking the SN:</p> <ul style="list-style-type: none"> <li>- assessed that the family needed to be instructed on medication administration for the patient</li> <li>- obtained a physician order for the imodium</li> <li>- assessed the frequency with which the patient was being given the imodium</li> </ul> <p>Additionally, the SN documented the patient was experiencing pain and instructed the aide to give tylenol every 4 hours until the pain resolved. Although it is not within the scope of tasks for a Home Health Aide (HHA) to administer medications to a non self directed patient, evidence is lacking the SN:</p> <ul style="list-style-type: none"> <li>- instructed the family on medication administration for the patient</li> <li>- clarified the plan of care for tylenol with the physician. Specifically, the plan included " Tylenol Arthritis Pain 650 mg: 1 tablet Oral PRN 24 hours, every 6 hours, 1 tab in am and 1 tab in pm for pain". The plan was not clear in the dose, and maximum dose for the tylenol.</li> <li>- assessed if the patient was taking ibuprofen</li> </ul>	G 172	<ul style="list-style-type: none"> <li>• Complete accurate assessment of bowel status and management and pain assessment and management with follow up to ensure interventions adequately address the symptoms ( patients #2, #11 no longer on service)</li> <li>• Complete, accurate assessment of emotional status (patient #11 no longer on service).</li> <li>• Scope of practice for home health aides and personal care aides (patient #2 no longer on service)</li> <li>• Requirement to document findings of nursing visits within 24 hours of the visit and to visit at the frequency specified in the plan or to notify the physician if the visit is not made with the reason why (patient #4 no longer on service)</li> </ul> <p>The DPS and or Designee will present an in-service on the <i>revised reassessment policies and procedures</i> to staff by <b>01/10/08</b>. The revised policies and procedures will be implemented by <b>01/15/08</b>.</p> <p>The DPS and or Designee will present an in service to staff by <b>01/15/08</b> on the following:</p> <ul style="list-style-type: none"> <li>• Completion of thorough, accurate nursing reassessments</li> <li>• scope of practice for home health aides and personal care aides, completion of aide care plans, and supervision of aides</li> </ul>	1/15/08	

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G 172	<p>Continued From page 64</p> <p>twice daily as needed for pain per the plan of care</p> <p>On 06/12/07 the the SN visited the patient and documented the patient fell over the weekend. Evidence is lacking the SN assessed the patient's pain status, or bowel status.</p> <p>On 06/15/07 the transfer nursing assessment indicated the patient went to the emergency room for nausea, dehydration, malnutrition, constipation, impaction, however, the SN failed to clarify specifically what the change in patient condition was. The supervisory notes indicated on 06/14/07 the patient was in the emergency room for increased diarrhea, weakness, and would possibly be admitted. Evidence is lacking the SN determined the status of the patient until 6 days later on 06/20/07.</p> <p>On 06/20/07 the patient returned home, and the SN performed a resumption of care assessment. The SN documented the patient was experiencing diarrhea, however, evidence is lacking she assessed if the patient was taking imodium, colace or metamucil, or discussed a bowel plan with the physician.</p> <p>On 07/10/07 the SN documented the patient was experiencing nausea and vaginal pain. Evidence is lacking the SN assessed the patient's use of tylenol or ibuprofen. Additionally, although the SN documented the patient was homebound due to bowel status, evidence is lacking the SN assessed the patient's bowel status.</p> <p>This record was reviewed with the AA and AC on 10/18/07, no additional information was provided.</p> <p>3. Patient #6 was admitted to the agency on</p>	G 172	<p><b>Evaluation of comprehensive care planning on a concurrent basis:</b></p> <p>The DPS and or Designee will assess compliance with the above on a concurrent basis through participation in patient case conferences conducted at the patient's start of care and every 2 weeks thereafter, and through case management audits beginning 01/15/08 (see G143)</p> <p><b>Evaluation of comprehensive nursing reassessment on a retrospective basis is incorporated into the 2 to 4 week record review process and the quarterly clinical record review process (see G250).</b></p>	<p>1/15/08</p> <p>Visios</p>	

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G 172	<p>Continued From page 65</p> <p>09/28/07 with a secondary diagnosis of head and neck cancer. The plan of care included: gastric tube feedings of jevity 4 times per day; 50ml of water before and after feedings; and wash gastric tube site daily and apply dry dressing.</p> <p>Although the SN visited 4 times from 09/28/07 - 10/03/07, evidence is lacking the SN ever assessed the gastric tube for patency or observed the patient performing the gastric tube site care or feedings.</p> <p>On 10/15/07 the SN documented a phone call with the patient indicating the gastric tube had been removed by the physician due to a blockage. Although the patient communicated the plan was to let the old gastric tube site heal, evidence is lacking the SN clarified with the physician what the wound care plan was; what the patient's diet was; or reassess the patient until 3 days later on 10/18/07.</p> <p>On 10/18/07 a different SN visited and discharged the patient. Although the SNs documented the patient weighed 152 pounds on 09/28/07 and 139 pounds on 10/18/07, and the patient's appetite was only fair, evidence is lacking the SN reported the 13 pound weight loss to the physician, or assessed the patient's caloric intake prior to discharging him from the agency on 10/18/07.</p> <p>Additionally the SN reported in the discharge assessment the patient had intractable pain; however, failed to assess if the patient was taking oxycodone or oxycontin per the plan of care. The SN discharged the patient without reporting to the physician that the patient was continuing to have pain.</p>	G 172			



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NAME OF PROVIDER OR SUPPLIER

**VNS ITHACA TOMPKINS CO CHHA**

STREET ADDRESS, CITY, STATE, ZIP CODE

**138 CECIL A MALONE DRIVE  
ITHACA, NY 14850**

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G 172	<p>Continued From page 66</p> <p>4. Patient #10 was admitted to the agency on 09/19/07. The plan of care indicated the SN was to make weekly visits for assessment of right buttocks pressure ulcer, and flap assessment. The nursing reassessments were incomplete as follows:</p> <p>On 10/05/07 the SN visited and discharged the patient. The SN documented the patient had been instructed to assess the skin flap on her buttocks with 2 mirrors, however, evidence is lacking the patient demonstrated being able to perform this prior to discharge.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>5. Patient # 4 was admitted to the agency on 09/26/07 with a primary diagnosis of uncontrolled diabetes, secondary diagnosis of foot ulcer. The plan of care included daily dressing changes. Evidence is lacking the SN visited daily from 09/26/07 - 10/16/07, or that the SN observed the primary caregiver performing the dressing independently.</p> <p>On 10/16/07 the surveyor requested the patient record for review. The surveyor questioned the AA as to where the SN notes were for after 10/01/07. The AA stated that the record contained all of the notes.</p> <p>On 10/17/07 the surveyor received additional documentation entered into the computerized record by the SN on 10/16/07 indicating: the SN had performed the dressing changes on 09/27/07, 09/28/07, and 10/05/07; the patient had been attending the wound center 3 times per</p>	G 172		

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NAME OF PROVIDER OR SUPPLIER  <b>VNS ITHACA TOMPKINS CO CHHA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>138 CECIL A MALONE DRIVE</b> <b>ITHACA, NY 14850</b>
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G 172	<p>Continued From page 67</p> <p>week for wound vac therapy/dressing changes</p> <p>Evidence is lacking the SN:</p> <ul style="list-style-type: none"> <li>- documented the patient's current status until after the surveyor inquired about the missing progress notes, making the documentation questionable for accuracy</li> <li>- clarified when the wound vac had been initiated</li> <li>- confirmed with the physician SN visits would no longer be needed for wound assessment/dressing changes prior to decreasing the SN visit frequency</li> </ul> <p>This record was reviewed with the AA and AC on 10/18/07, no additional information was provided.</p> <p>6. Patient #1 was admitted to the home care agency on 9/11/2007 with secondary diagnoses of type 2 diabetes mellitus and nausea and vomiting. The plan of care included zofran (anti nausea) 8 mg every four hours for nausea and vomiting. The 09/11/07 initial nursing assessment indicated the patient's weight was 155 pounds. Evidence is lacking the SN reassessments were complete as follows:</p> <ul style="list-style-type: none"> <li>- On 10/02/07, 10/09/07 the SN documented the patient's weight was 145 pounds, and on and 10/30/07 a weight of 139 pounds. Although the patient had experienced a 16 pound weight loss since admission, and the SN documented the patient had decreased appetite; was not drinking well; and was experiencing nausea and vomiting, evidence is lacking the SN assessed the patient's caloric intake, or whether he was taking the zofran per the plan of care.</li> </ul> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was</p>	G 172		

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G 172	Continued From page 68 provided.  7. Patient #13 was admitted to the agency on 09/07/07. The 09/07/07 initial nursing assessment indicated the patient had wounds and edema of the left lower extremity. Evidence is lacking the SN re assessments were accurate as follows:  On 09/07/07 the SN documented in the initial nursing assessment the edema measurements obtained were measured over the dressing on the wound. The SN measured the left lower extremity 6 times between 09/07/07 and 10/22/07, and the measurements varied 3 cm for the left calf, 8 cm for left ankle, 8.5 cm for left instep during this time period, however, it is unclear if the measurements were done with the dressings on as well. Specifically, the edema measurements would not be accurate if done over the dressing.  This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.	G 172	<b>G174 DUTIES OF THE REGISTERED NURSE</b>  The DPS and/or Designee will review and or revise where appropriate policies and procedures related to nursing supervision and agency nursing policies and procedures by <b>01/08/08</b> . The DPS and or AA will present the revised policies and procedures to the Professional Advisory Committee (PAC) by <b>01/09/08</b> for review and approval and to the Governing Authority for review and approval by <b>01/10/08</b> .  The policies and procedures will include but not be limited to the following:  • Nursing skills competency checklist completed upon employment and at least annually thereafter. Current nurse employees will complete a skills competency checklist by <b>01/04/08</b> . Based on information provided additional training will be arranged as required and or patient case assignments may be temporarily rearranged. No nurse will perform a skill prior to DPS or Designee determination that that nurse is competent to perform the skill consistent with agency policy and procedure and professional standards of practice.	1/8/08 1/9/08 1/10/08
G 174	<b>484.30(a) DUTIES OF THE REGISTERED NURSE</b>  The registered nurse furnishes those services requiring substantial and specialized nursing skill.  This STANDARD is not met as evidenced by: Based on a review of 22 clinical records, 5 observational home visits, and interviews with the Agency Administrator (AA), Director of Nursing (DON), and Agency Consultant, evidence was lacking in 3 records the agency's registered nurses demonstrated substantial and specialized	G 174		1/4/08

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G 174	<p>Continued From page 69</p> <p>skill/knowledge to meet the needs of the patient. Patients# 5, 7, 13</p> <p>Failure of the Skilled Nurses (SN) to possess adequate knowledge and skill has the potential for unmet patient needs and possible negative patient outcomes.</p> <p>Examples are as follows:</p> <p>1. Patient #13 was admitted to the agency on 09/07/07. The 09/07/07 initial nursing assessment indicated the patient had wounds and edema of the left lower extremity. Evidence is lacking the SN demonstrated adequate knowledge about edema assessment as follows:</p> <p>On 09/07/07 the SN (employee P) documented in the initial nursing assessment the edema measurements obtained were measured over the dressing on the wound. The SN measured the left lower extremity 6 times between 09/07/07 and 10/22/07, and the measurements varied 3 cm for the left calf, 8 cm for left ankle, 8.5 cm for left instep during this time period, however, it is unclear if the measurements were done with or without the dressing on. Evidence is lacking the SN was aware that accurate edema measurements cannot be obtained over a dressing, or that the Nursing Supervisor identified this problem. Additionally the SN failed to clarify reporting parameters for edema with the physician.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>HV</p>	G 174	<ul style="list-style-type: none"> <li>DPS or Designee in home evaluation of nurse skills, knowledge, and competency through out orientation, annually, and as needed based on individual educational needs. The DPS or Designee will complete a home visit with each nurse currently on staff by 01/08/08 to observe skills and knowledge. Based on observations and or discussion additional training will be arranged as required and or patient case assignments may be temporarily rearranged</li> <li>Extensive orientation and mentoring program</li> <li>Nursing Supervision</li> </ul>	1/15/08

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G 174	<p>Continued From page 70</p> <p>2. Patient #5 was admitted to the agency on 10/08/07 with a primary diagnosis of methicillin resistant staphylococcus aureus post operative infection (MRSA) of a chest wound. The plan of care included vancomycin intravenously and daily dressing changes which included packing the wound with kerlix gauze soaked in 1/4 betadine and 3/4 normal saline. The SN (employee Q) failed to demonstrate adequate knowledge about sterile dressing technique as follows:</p> <p>On 10/22/07 the surveyor made an observational home visit with the SN. Evidence was lacking the SN ensured that the betadine and normal saline solutions which were being used were not expired. Specifically, the SN failed to label the containers of betadine and normal saline with the date and time they were opened.</p> <p>Additionally, evidence is lacking the SN ensured the dressings removed from the patient's wound were properly disposed of. Although the patient was being treated for MRSA at the wound site, the skilled nurse failed to dispose of the soiled dressings per agency policy. Specifically, following the dressing change, the SN disposed of the heavily soiled dressing in an open, plastic lined trash can, which was left open in the patient's home. The agency's policy for Disposal of Soiled Dressings specifies: 1. place all soiled wound dressings in a plastic trash bag. 2. spray with 10% bleach solution if heavily soiled 3. Seal and place in a second plastic bag if the dressings are heavily soiled or if leakage is a possibility. Place the plastic bag in the family's trash.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p>	G 174			

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G 174	<p>Continued From page 71</p> <p>HV</p> <p>3. Patient # 7 was admitted to the agency on 10/24/07. On 10/24/07 an observational home visit was conducted by the surveyor with the SN for the initial nursing assessment. The surveyor observed the patient had a subcutaneous catheter in his right lower extremity for the daily infusion of neupogen. Evidence is lacking the SN (employee O) possessed adequate knowledge about subcutaneous catheter as follows:</p> <p>The agency failed to develop a policy that had been reviewed and approved by their PAC committee prior to the SN implementing the procedure. Additionally, the agency failed to provide education to the SN regarding subcutaneous catheters.</p> <p>The 10/21/07 hospital referral contained a hospital policy / procedure for subcutaneous infusion catheters, and on 11/13/07 the surveyor interviewed the AA and DPS. The AA stated she thought the procedure could be implemented as long as a physician had prescribed it. Evidence is lacking however, the policy/procedure was signed by the physician as an order, or was appropriate for home care. Specifically, the policy indicated the nurse is to check the site daily for irritations or other complications, and document in patient assessment on daily flow sheet. The plan of care however, included only weekly SN visits, and evidence is lacking the policy or plan of care addressed whether the family should observe and record the status of the catheter site daily.</p> <p>Additionally, the policy specified the catheter should be changed every 7 days, and the dates should be recorded on the medication</p>	G 174			

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G 229	<p>Continued From page 73</p> <p>potential for unmet patient needs, and possible negative patient outcomes.</p> <p>1. Patient #3 was admitted to the agency's LTHHCP on 05/04/06. The 08/27/07 plan of care included: SN visits every 2 weeks for assessment of the patient's cardio-pulmonary status, and emotional status, and HHA's 3 times per week.</p> <p>Although the patient was receiving SN visits for assessment every 2 weeks, the plan of care included HHA supervision only monthly, and evidence is lacking the SN supervised the HHA every 2 weeks. Specifically, the patient record included the following aide supervisions: 06/10/7, 07/16/07, 09/26/07, 10/25/07, 10/26/07.</p> <p>This record was reviewed with the AA and AC on 10/18/07, no additional information was provided.</p> <p>2. Patient #5 was admitted to the agency on 05/25/07. The 05/25/07 and 07/24/07 plans of care included SN visits every 2 weeks for assessment, and evidence is lacking the SN supervised the HHA every 2 weeks. Specifically, the SN supervised the aide only on 06/04/07, 07/17/07, 07/20/07, 09/07/07. Additionally, the agency policy specifies the aide must be present for every other supervision by the SN. Evidence is lacking the aide was present for the supervision on 07/17/07, 07/20/07 or 09/07/07.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>3. Patient #14 was admitted to the agency's LTHHCP on 05/25/07. Although the plan of care</p>	G 229	<p><b>Evaluation of Home Health Aide supervision on a concurrent basis:</b></p> <p>The DPS and or Designee will assess compliance with the above on a concurrent basis through participation in patient case conferences conducted at the patient's start of care and every 2 weeks thereafter, and through case management audits beginning <b>01/15/08</b> (see G143)</p> <p><b>Evaluation of comprehensive nursing reassessment on a retrospective basis is incorporated into the 2 to 4 week record review process and the quarterly clinical record review process</b> (see G250).</p>	<p>1/15/08</p> <p>1/15/08</p>



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G 229	Continued From page 74 included SN visits every 1- 2 weeks for assessment, the SN failed to supervise the HHA every 2 weeks. Specifically, the SN supervised the aide only on: 06/04/07, 07/20/07, 09/07/07, 09/13/07, 10/04/07, and 11/14/07. Additionally, the agency policy specifies the aide must be present for every other supervision by the SN. Evidence is lacking the aide was present for any supervisions conducted from 06/04/07 - 09/13/07 or from 10/04/07-11/14/07.	G 229	<b>G235 CLINICAL RECORDS</b>  The DPS, AA, and or Designee will implement policies and procedures to direct and maintain a functional and effective system of documentation at all times to promote quality health care, by 1/15/08.	1/15/08
G 235	<b>484.48 CLINICAL RECORDS</b>  This CONDITION is not met as evidenced by: o Failure to develop and maintain a functional and effective system of documentation that provides the following: - an accurate assessment of the patient's needs - a clear and comprehensive identification of patient problems - a consistent, accurate, and organized plan of care - evidence of case management and communication among all interdisciplinary team members, including the physician - reliable data resulting from an ongoing assessment of each patient's response to treatment - modification of the plan of care based on the patient's response to treatment - an assessment of the patient's progress relative to the attainment of measurable outcomes  o Failure to ensure nursing reassessments are accessible to all staff who are responsible for providing care within an acceptable time frame.	G 235	Clinical records will contain an accurate assessment of the patient's needs, a clear and comprehensive identification of patient problems, a  consistent, accurate and organized plan of care, evidence of effective case coordination and communication among all interdisciplinary team members including the physician, reliable data resulting from ongoing assessment of each patient's response to treatment, modification of the care plan based on response to treatment, and assessment of the patient's progress in attaining the goals. The DPS and or Designee will complete quality improvement activities to monitor compliance; concurrent and retrospective record audits, of sufficient scope to ensure that areas in need of improvement are identified. (See G109, G143 G158, G159, G164, G171, G172, G174, G229, G236, G250).	1/15/08

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G 235	Continued From page 75 See G236	G 235		
G 236	<p>The cumulative effect of these systemic problems of incomplete/inadequate documentation compromised the home care agency's ability to ensure the provision and coordination of quality health care, and has the potential for agency wide negative patient outcomes.</p> <p>484.48 CLINICAL RECORDS</p> <p>A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 22 clinical records, 5 observational home visits, and interviews with the Agency Administrator (AA), Director of Nursing (DON) and Agency Consultant (AC), evidence is lacking in 8 records that all pertinent information is contained in the clinical record. Specifically, although agency policy specifies the Skilled Nurse (SN) is expected to complete the day's documentation before leaving for the day, the clinical progress notes are not being recorded in a timely manner, and in accordance with agency policy. Specifically, documentation is being submitted as late as 6 weeks late, and as a result, information concerning patient status and patient response to treatment: is not readily</p>	G 236	<p><b>G 236 CLINICAL RECORDS</b></p> <p>The DPS, AA, and or Designee will revise the clinical record policies and procedures to indicate that nurse clinical progress notes are to be completed within 24 hours of a visit. The DPS and or AA will present the revised policies and procedures to the Professional Advisory Committee (PAC) by 01/09/08 for review and approval and to the Governing Authority for review and approval by 01/10/08. The revised policy and procedure will be implemented by 1/15/08.</p> <p>Patients #2, #3, #4, #14, #16 were identified to have late nursing note entries, however only #3 and #14 remain on service. Nursing note entries on these and all records will be current within 24 hours of a visit by 1/04/08.</p> <p>The Technology Designee will provide documentation of dates of nurse visits on a weekly basis for each nurse to be used by support staff to audit patient records for compliance with the 24 hour documentation requirement.</p> <p>Support staff will complete chart audits on 100% of the visits made by each nurse on a weekly basis to ensure that documentation is completed within 24 hours after a patient visit. When a nurse's compliance rate reaches 90% or greater, the chart audits will drop to</p>	<p>1/9/08</p> <p>1/10/08</p> <p>1/15/08</p> <p>1/4/08</p> <p>1/15/08</p>

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G 236	<p>Continued From page 76</p> <p>available to all clinicians responsible for implementing the plan of care; readily available to supervisors responsible for overseeing the delivery of patient care; is questionable for accuracy and authenticity.</p> <p>Additionally, evidence is lacking clinical records are accurate and complete. Specifically, patient records contain inconsistent documentation for the presence, location, and status of all wounds and edema, and inaccurate transfer OASIS information. Patients# 2, 3, 4, 10, 13, 14, 16</p> <p>Failure of the agency to ensure complete, accurate, and current documentation is readily available creates the potential for agency clinicians and supervisors to make incorrect decisions based on inaccurate information, and agency wide negative patient outcomes.</p> <p>Examples are as follows:</p> <p>1. Patient #13 was admitted to the agency on 09/07/07. The SN documentation was inaccurate, incomplete, and not timely as follows:</p> <p>- On 09/28/07 the SN measured 7 wounds, however, failed to number the wounds. On 10/11/07 the SN depicted 2 wounds, however failed to number them or indicate which wounds had resolved. On 10/22/07 the SN documented 3 wounds and depicted wound #3 as anterior right calf, however wound #3 was described as the left ankle on 09/07/07.</p> <p>- The computer indicated nursing progress notes dated: 09/18/07, 09/28/07, 10/01/07, 10/04/07 had not been entered until 10/15/07.</p>	G 236	<p>50% of all visits made by that nurse in a week. If a nurse's compliance rate drops below 90%, the audit frequency will return to 100%. The support staff will document the chart audits on a tool to be developed by 1/15/08.</p> <p>The DPS or Designee will trend the results of these audits by individual and by group on a monthly basis or sooner based on results of data (weekly at present).</p> <p>The DPS and or Designee will meet with the AA on a monthly basis (1<sup>st</sup> Tuesday of each month) or more frequently if compliance rates are below 90% (weekly at present) to discuss and analyze the results of the audits. Areas identified to be in need of improvement will be identified and corrective action plans will be developed, implemented and monitored. Corrective actions planned may be by group or by individual.</p> <p>The DPS or Designee will provide the agency Human Resources Designee with a copy of individual audit trending results for filing in that individuals personnel file for use in staff development and performance evaluations.</p> <p>The DPS or Designee will provide the PAC and Governing Authority with the trended case management audit results and individual audit findings quarterly or sooner based on results for review and action.</p>	<p>1/15/08</p> <p>1/15/08</p> <p>1/15/08</p> <p>1/15/08</p> <p>1/15/08</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>337212</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/19/2007</b>
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NAME OF PROVIDER OR SUPPLIER

**VNS ITHACA TOMPKINS CO CHHA**

STREET ADDRESS, CITY, STATE, ZIP CODE

**138 CECIL A MALONE DRIVE  
ITHACA, NY 14850**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 236	<p>Continued From page 77</p> <p>- Following the surveyors review of the record on 10/23/07, the SN submitted hand written nursing progress notes dated 10/23/07 as late entries for visits made on 09/08/07, 09/09/07, 09/18/07, 09/24/07.</p> <p>Additionally, the SN documented weekly edema measurements on the wound flow sheet, and failed to specify the measurements were for edema.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p> <p>2. Patient # 4 was admitted to the agency on 09/26/07. On 10/16/07 the surveyor reviewed the record and asked the AA if there were any nursing progress notes missing. The AA stated all notes were in the record.</p> <p>On 10/17/07 the SN submitted to the surveyor progress notes dated 09/27/07, 09/28/07, 10/01/07, 10/03/07, 10/05/07, 10/06/07. The computer indicated these notes had not been entered until 10/16/07.</p> <p>This record was reviewed with the AA and AC on 10/18/07, no additional information was provided.</p> <p>3. Patient #10 was admitted to the agency on 09/19/07. Although the patient was discharged from nursing services on 10/05/07, the SN failed to notify the physician or submit a patient summary until 10 days later on 10/15/07.</p> <p>This record was reviewed with the AA and DON on 11/13/07, no additional information was provided.</p>	G 236	<p>Clinical records will contain an accurate assessment of the patient's needs, a clear and comprehensive identification of patient problems, a consistent, accurate and organized</p> <p>plan of care, evidence of effective case coordination and communication among all interdisciplinary team members including the physician, reliable data resulting from ongoing assessment of each patient's response to treatment, modification of the care plan based on response to treatment, and assessment of the patient's progress in attaining the goals, the DPS and or Designee will implement quality improvement activities such as concurrent and retrospective record audits of sufficient scope to ensure that areas in need of improvement are identified. (See G109, G143 G158, G159, G164, G171, G172, G174, G229, G236, G250).</p>	1/15/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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ITHACA, NY 14850**

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G 236	<p>Continued From page 78</p> <p>4. Patient #2 was admitted to the agency on 06/06/07. The patient's hospital record indicates on 10/15/07 the patient was admitted for a urinary tract infection, however the 06/15/07 transfer OASIS indicated the patient was seen in the emergency room for dehydration, malnutrition, constipation, impaction. The OASIS failed to specify why the patient required emergent care, and failed to indicate the patient had been admitted to the hospital.</p> <p>This record was reviewed with the AA and AC on 10/18/07, no additional information was provided.</p> <p>5. Patient #16 was admitted to the agency on 03/07/07. On 08/17/07 the SN documented a phone call to the physician indicating a SN visit was made the prior day. The patient record failed to contain documentation of a SN visit on 08/16/07.</p> <p>Additionally, on 08/31/07 a transfer OASIS was completed which indicated the patient was admitted to the hospital, however, the transfer OASIS failed to specify the reason for hospitalization.</p> <p>6. Patient # 14 was admitted to the agency on 08/28/07. Following the surveyors review of the record the SN submitted nursing progress notes dated 09/07/07 and 10/04/07. The computer indicated the notes had been entered on 10/31/07.</p> <p>7. Patient #3 was admitted to the agency on 05/04/06. On 10/16/07, following the surveyor's</p>	G 236		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>337212</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/19/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>VNS ITHACA TOMPKINS CO CHHA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>138 CECIL A MALONE DRIVE</b> <b>ITHACA, NY 14850</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 242	Continued From page 80 o The accuracy and completeness of patient assessments, and that nurses are qualified and knowledgeable. See G 171, G 172, G 174  o The accuracy, completeness, and implementation of plans of care. See G 158, G 159  o That complete, accurate, and current documentation in patient records, is readily available. G 236  o The extent to which the agency's program is appropriate, adequate, effective and efficient. See G 245  o That the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient. G 248  o The quality and appropriateness of patient care. See G250  The cumulative effect of these systemic problems related to the agency's annual evaluation, resulted in the home care agency's inability to ensure the provision of quality care and a negative outcome for patients # 1, 2, 6, 8, 11, 13.	G 242	G171, G172, G174, G229, G236, G250).  The AA, DPS or Designee will participate in all agency quality improvement activities, facilitate the identification of problems and development of plans of correction/monitoring/reporting for all identified problems, trend deficiencies, review all meeting minutes for accuracy and clarity, be prepared to report on all corrective actions taken at the next meeting, and maintain a copy of all minutes of the meetings in a location that ensures ready availability and accessibility.  The AA, DPS, and or Designee will report/share the findings of all quality improvement committees including PAC at least quarterly if not more frequently and with the Governing Authority monthly or more frequently (see G133, G140, G143, G243, G250, and G330).	1/15/08	
G 245	484.52 EVALUATION OF THE AGENCY'S PROGRAM  The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient.	G 245	<b>G245 EVALUATION of the AGENCY PROGRAM</b>  The AA, DPS, PAC, and Governing Authority will coordinate an agency annual evaluation to accurately determine the extent to which the program is appropriate, adequate, effective and efficient by 3/08 (see G236, G242), G250).	Ongoing  3/08	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/19/2007
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VNS ITHACA TOMPKINS CO CHHA

138 CECIL A MALONE DRIVE  
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G 245

Continued From page 81

This STANDARD is not met as evidenced by:  
Based on a review of: the agency's 03/23/07  
Annual Program Evaluation for 2006 Services,  
Professional Advisory Committee (PAC) meeting  
minutes for 2007, and Quality Assurance/Quality  
Improvement (QA/QI) reviews of patient records,  
evidence is lacking the Annual Program  
Evaluation is of sufficient scope to determine the  
extent that the agency's services are appropriate,  
adequate, effective and efficient.

Evidence is lacking the Program Evaluation  
identified, or developed a plan to resolve serious  
agency problems as identified in this report.  
Although the annual report indicated the overall  
compliance rate for start of care and  
comprehensive audits was 91%, the agency  
failed to develop a successful plan to:  
- correct the problems identified in the 01/24/07  
Department of Health survey, specifically:  
developing the plan of care G 159, and initial  
nursing assessments G171  
- intensify their QA activities to identify and correct  
the additional problems outlined in this report to  
include: patient rights G 108, G109; coordination  
of care G143; supervision of professional staff G  
140; supervision of aide staff G 229; submission  
of accurate and timely reports G236; nursing  
reassessments G172; skills and knowledge of the  
professional staff G 174.

Failure of the agency's annual evaluation to  
accurately determine the extent that the program  
is appropriate, adequate, effective and efficient  
has resulted in negative outcomes for patients #  
1, 2, 6, 8, 11, 13, and has the potential for agency  
wide unmet patient needs and negative patient  
outcomes. See G 250

G 245



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>337212</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/19/2007</b>
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**ITHACA, NY 14850**

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G 245	Continued From page 82	G 245	<b>G 250 CLINICAL RECORD REVIEW</b>	
G 250	<p><b>484.52(b) CLINICAL RECORD REVIEW</b></p> <p>At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.</p> <p>This STANDARD is not met as evidenced by: Based on a review of the quality assurance program, Professional Advisory Committee (PAC) meeting minutes, Governing Body meeting minutes and interviews with the Agency Administrator (AA), Director of Nursing (DON), and Agency Consultant (AC), evidence is lacking the agency's Quality Assurance/ Quality Improvement (QA/QI) program identified and corrected recurring systemic agency problems. Specifically:</p> <p>1. The agency 's patient record reviews conducted by the Agency Consultant were narrow in scope, and identified problems only with: developing plan of care; following plan of care; initial nursing assessments; reporting changes in patient condition to the physician. The QA/QI program failed to intensify their QA activities to ensure the following additional problems were identified and corrected as outlined in this report: patient rights G 108, G109; coordination of care G143; nursing reassessments G172; supervision of professional staff G 140; supervision of aide staff G 229; submission of accurate and timely</p>	G 250	<p>The AA, DPS, and or Designee will revise and intensify the agency's quality improvement program policies and procedures by <b>01/08/08</b>. The comprehensive audit tool will be revised and will be of sufficient scope to identify areas in need of improvement and effectiveness of the plan of correction to address deficiencies identified. The patient complaint procedure will be revised to include a written response to the complainant regarding the outcome of the investigation routinely. The Patient Satisfaction Survey will be revised to incorporate questions regarding patient rights. The DPS and or AA will present the revised policies and procedures to the Professional Advisory Committee (PAC) by <b>01/09/08</b> for review and approval and to the Governing Authority for review and approval by <b>01/10/08</b>.</p> <p>The AA, DPS, and or Designee will on a quarterly basis in accordance with agency policies and procedures select a sample of records for review by appropriate health professionals. The sample will include both active and closed patient records representing the scope of services. The 4<sup>th</sup> quarter review for 2007 will be completed by <b>2/01/08</b>.</p>	<p>1/8/08</p> <p>1/8/08</p> <p>1/9/08</p> <p>1/10/08</p> <p>2/1/08</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER

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STREET ADDRESS, CITY, STATE, ZIP CODE

138 CECIL A MALONE DRIVE  
ITHACA, NY 14850

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G 250	<p>Continued From page 83</p> <p>reports G236; skills and knowledge of the professional staff G 174.</p> <p>2. The PAC failed to correctly interpret the trends that were being identified in the patient records by the Agency Consultant. Specifically, the record reviews indicated no upward trends for compliance, and in some cases downward trends for January 2007 - September 2007. Evidence is lacking the PAC correctly interpreted and reported these trends to the Governing Body, or developed strategies for improvement. Specifically, the Agency Consultant reported:</p> <ul style="list-style-type: none"> <li>- January - March 2007 quarterly patient record review: insufficient plan of care in 5 of 11 records; failure to follow the plan of care in 3 of 10 records ; inadequate initial nursing assessments in 7 of 10 records; failure to report changes in patient condition in 2 of 11 records.</li> <li>- April - June 2007 quarterly patient record review: insufficient plan of care (medications) in 4 of 8 records; failure to follow the plan of care in 3 of 8 records; inadequate initial nursing assessments in 3 of 8 records ; inadequate care coordination in 1 of 8 records.</li> <li>- April 2007 comprehensive patient record reviews: insufficient plan of care in 6 of 12 records; inaccurate medication plan in 7 of 12 records; failure to follow the plan of care in 6 of 12 records; inadequate initial nursing assessments in 9 of 12 records</li> <li>- August 2007 comprehensive patient record: insufficient plan of care in 6 of 6 records; failure to</li> </ul>	G 250	<p>The AA, DPS, and or Designee will trend the results of the quarterly clinical record reviews as well as the results of all other quality improvement activities and accurately interpret the data for the PAC and Governing Authority for review and action by 1/15/08.</p> <p>The DPS and or Designee will implement a plan for accurate medication reconciliation by 1/15/08 (see G159)</p> <p>The AA, DPS, or Designee will implement a plan to assess nurse compliance with the agency's policy requiring nurse documentation of visit findings within 24 hours of completion of visit by 1/15/08. (see G236)</p> <p>The AA will evaluate nurse retention problems related to issues of salary and benefits and develop a proposal for retention for presentation to the Governing Authority by 3/01/08. (see G 133).</p>	<p>1/15/08</p> <p>1/15/08</p> <p>1/15/08</p> <p>3/1/08</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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G 250	<p>Continued From page 84</p> <p>follow the plan of care in 2 of 6 records; inadequate initial nursing assessments in 3 of 6 records.</p> <p>- September 2007 comprehensive patient record reviews: insufficient plan of care in 8 of 12 records; inaccurate medication plan in 10 of 12 records; failure to follow the plan of care 4 of 12 records; inadequate initial nursing assessments in 7 of 12 records.</p> <p>Despite lack of any improvement in the above trends, the 07/20/07 PAC notes documented areas need improvement including aide care plans, nursing assessments, plans of care, medication discrepancies. However the PAC also documented the QA consultant is continuing to see improvement in chart reviews, and failed to develop a plan for improvement.</p> <p>On 10/05/07 the 09/10/07 PAC minutes were reported to the governing authority. The PAC reported the same deficiencies appear on all reports, and other than the deficiencies noted, compliance in other areas is very high. Evidence is lacking the PAC or Governing Body developed an aggressive plan to resolve the significant deficiencies continuing to appear on all reports. This resulted in the agency failing to provide safe and appropriate patient care, and failing to correct the deficiencies cited on the 01/24/07 recertification survey, specifically, plan of care G159 and nursing assessments G 171, G 172.</p> <p>3. The agency identified the following additional problems, however, failed to implement an effective plan to resolve the problems:</p>	G 250		

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G 250	<p>Continued From page 85</p> <p>-On 06/04/07 and 09/10/07 the PAC identified inaccurate hospital discharge information as a possible cause for the agency's inaccurate medication plans, however, evidence is lacking the PAC identified, and reported to the Governing Body that the AA and Supervising Nurse had been failing to identify plan of care medication discrepancies during the start of care reviews.</p> <p>- On 07/20/07 the Governing Body meeting minutes indicated nurses were being encouraged to complete documentation on "day of visit while still fresh in their minds" and that the board supported time frames, and the use of computers. Evidence is lacking the Governing Body: developed a plan to include timely submission of nursing notes into the patient record reviews; ever reevaluated the problem; identified late submission of nursing notes as a significant continuing problem as outlined in this report. SEE G 236</p> <p>- On 7/20/07 the Governing Body minutes indicated staff retention was discussed regarding caseload. On 11/09/07 the surveyor interviewed the AA, who stated salary and benefits were causing a high turnover in the nursing staff, and that a competing agency had higher salaries and better benefits as well as lower caseloads. The surveyor questioned if the AA had brought this to the attention of the governing body. The AA initially stated she had, however, then stated it would not matter if she had because if the agency increased their salaries, the competing agency would do the same. Evidence is lacking however, the issue of salary and benefits was ever discussed with the Governing Body.</p> <p>Failure of the agency's Quality Assurance/ Quality</p>	G 250		

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NAME OF PROVIDER OR SUPPLIER  <b>VNS ITHACA TOMPKINS CO CHHA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>138 CECIL A MALONE DRIVE</b> <b>ITHACA, NY 14850</b>
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G 250	Continued From page 86 Improvement (QA/QI) program to identify and correct recurring systemic agency problems has resulted in negative patient outcomes for patients # 1, 2, 6, 8, 11, 13, and has the potential for agency wide unmet patient needs, and negative patient outcomes.	G 250		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337255	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/15/2009
NAME OF PROVIDER OR SUPPLIER  GENTIVA HEALTH SERVICES LIVERPOOL			STREET ADDRESS, CITY, STATE, ZIP CODE 200 ELWOOD DAVIS ROAD LIVERPOOL, NY 13088		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 000	<p>INITIAL COMMENTS</p> <p>The following statement of deficiencies is the result of a recertification survey and an onsite investigation of 4 complaints: NY00066934, NY00066961, NY00066182, NY00069327.</p> <p>A post certification survey of the agency was commenced on 1/13/09. The post certification survey was initiated as a follow up to the recertification survey completed on August 13, 2008, event SG7Q11.</p> <p>On January 21, 2009, it was determined that none of the citations identified on the August 13, 2008 survey had been corrected, and additional deficiencies were identified. The survey was converted to an extended survey, which consisted of a review of a total of 41 patient records, including 25 observational home visits. Clinical record reviews and observational home visits were conducted at the parent office as well as the two branch offices, located in Oswego and Auburn, New York.</p> <p>Deficient practices were identified at condition level non-compliance in the following 5 Conditions of Participation: Organization, Services and Administration; Group of Professional Personnel; Acceptance of Patients, Plan of Care, and Medical Supervision; Skilled Nursing Services; and Evaluation of the Agency's Program. Negative outcomes were identified for a total of seven patients: #1, 2, 6, 26, 27, 30, 37, and the potential for negative outcomes for the agency's entire patient population.</p> <p>Interviews were conducted with the Administrator (hired 10/30/08 and reassigned on 02/04/09), acting Administrator, Director of Clinical</p>	G 000	<p><i>POC #3</i></p> <p><i>The following patients are discharged:</i></p> <p><i>#1 #2 #3 #4 #5</i></p> <p><i>#6 #7 #8 #9 #10 #11</i></p> <p><i>#12 #14 #15 #16</i></p> <p><i>#17 #18 #19 #20</i></p> <p><i>#23 #24 #26 #27</i></p> <p><i>#28 #29 #30 #31 #32</i></p> <p><i>#33 #34 #35 #36</i></p> <p><i>#37 #38 #39 #40</i></p> <p><i>#21 order for eye gtu obtained</i></p> <p><i>#13 in hospital presently</i></p> <p><i>#22 AN put on action plan and documentation review</i></p>		

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Sharon Delavero RN BSN AD 5/14/09

deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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NAME OF PROVIDER OR SUPPLIER  GENTIVA HEALTH SERVICES LIVERPOOL			STREET ADDRESS, CITY, STATE, ZIP CODE 200 ELWOOD DAVIS ROAD LIVERPOOL, NY 13088		
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G 000	<p>INITIAL COMMENTS</p> <p>The following statement of deficiencies is the result of a recertification survey and an onsite investigation of 4 complaints: NY00066934, NY00066961, NY00066182, NY00069327.</p> <p>A post certification survey of the agency was commenced on 1/13/09. The post certification survey was initiated as a follow up to the recertification survey completed on August 13, 2008, event SG7Q11.</p> <p>On January 21, 2009, it was determined that none of the citations identified on the August 13, 2008 survey had been corrected, and additional deficiencies were identified. The survey was converted to an extended survey, which consisted of a review of a total of 41 patient records, including 25 observational home visits. Clinical record reviews and observational home visits were conducted at the parent office as well as the two branch offices, located in Oswego and Auburn, New York.</p> <p>Deficient practices were identified at condition level non-compliance in the following 5 Conditions of Participation: Organization, Services and Administration; Group of Professional Personnel; Acceptance of Patients, Plan of Care, and Medical Supervision; Skilled Nursing Services; and Evaluation of the Agency's Program. Negative outcomes were identified for a total of seven patients: #1, 2, 6, 26, 27, 30, 37, and the potential for negative outcomes for the agency's entire patient population.</p> <p>Interviews were conducted with the Administrator (hired 10/30/08 and reassigned on 02/04/09), acting Administrator, Director of Clinical</p>	G 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Sharon Delavero RNBSN AP 5/8/09

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution's safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 000	Continued From page 1  Management, acting Director of Clinical Management, Director of Performance Improvement, Supervising Nurses and staff members throughout the survey.  The following agency records were requested and reviewed during the extended survey: administrative and clinical policies and procedures, Professional Advisory Committee meeting minutes for 2007 and 2008, Governing Body meeting minutes for 2008, the agency's Annual Program Evaluation for 2007, Quality Improvement Program, the agency's Adverse Event Outcome Report for the period 8/08 to 10/08, Emergency Preparedness Plan, on-call log, and complaint log for the parent and each branch office.  Additionally, 33 personnel records were reviewed for professional and para-professional staff.  Throughout the survey, each clinical record chosen as part of the sample was reviewed with the acting Administrator, acting Director of Clinical Management and Supervising Nurses.	G 000			
G 118	484.12(a) COMPLIANCE WITH FED, STATE, LOCAL LAWS  The HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations. If State or applicable local law provides for the licensure of HHAs, an agency not subject to licensure is approved by the licensing authority as meeting the standards established for licensure.  This STANDARD is not met as evidenced by: Evidence is lacking that the agency is in	G 118 <i>5/15/09 acceptable Paula Williams HHS</i>	G118 484.12(a) Compliance with Federal, State and Local laws and Regulations  The two registered nurses N and Z have obtained a written document/clearance from their physician stating that they are not actively infected with TB. Date: N has the documentation 4/21/09 and Z 4/01/09. This documentation has been placed in their personnel files. In addition a position was added to the branches to perform all personnel activities and ensure compliance.		<i>4/21/09</i> <i>4/01/09</i>



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G 118	<p>Continued From page 2</p> <p>compliance with all applicable Federal, State, and local laws and regulations. Specifically, the agency failed to ensure that Title 10 of NYCRR Part 763.13 (4) are implemented as follows:</p> <p>Based on review of 2 of 2 registered nurses with a history of testing positive during a ppd skin test for tuberculosis, and interviews with the acting Administrator, evidence is lacking that appropriate clinical follow-up was complete. Employees N, Z</p> <p>Failure to conduct appropriate clinical follow-up to positive tuberculosis findings has the potential for exposure of patients and employees to tuberculosis.</p> <p>Specifically:</p> <p>Employee N had a history of a positive PPD in 1978. Evidence of a chest x-ray on 11/6/06 showed negative results. Another chest x-ray was completed 4/21/08, stating "negative PA chest." Evidence was lacking that the employee's primary physician reviewed the x-ray results and either made recommendations for follow-up, if necessary, or cleared the employee to work.</p> <p>Employee Z had a chest x-ray completed on 4/1/08 due to history of a cough, with stated results of "no acute disease of the chest." Evidence was lacking that the employee's primary physician reviewed the x-ray results and either made recommendations for follow-up, if necessary, or cleared the employee to work.</p> <p>This was reviewed with the acting Administrator on 02/09/09. No further evidence was provided.</p>	G 118	<p>10 Personnel Files will be audited by the RC 2 (records coordinator) each quarter to ensure required documentation is present in the files. A summary of this audit will be provided to administrator and this audit will be incorporated in the PAC meetings. This will begin May 11, 2009.</p> <p>In addition the RC2 will run employee compliance report that has all employees listed and attend the morning meetings biweekly to inform the MCP staff of: Status of CPR/TB renewals License renewals Performance evaluations Supervised visits required. This will monitored by the employee compliance report and those areas not completed by the due date, the RC2 will complete a report for the Administrator, monthly as the process will be proactively identifying compliance requirements a month previous to the expiration. The Administrator/DPS will follow-up with the MCP.</p> <p>The administrator is responsible for compliance with this standard. Lack of compliance will lead to disciplinary activities. Disciplinary actions will be documented and placed in their personnel files.</p>		<p>5/27/09 or on going</p> <p>5/27/09 or on going</p>
G 122	484.14 ORGANIZATION, SERVICES & ADMINISTRATION	G 122	<p>a acceptable Paul Williams RN 5/15/09</p>		

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G 122	Continued From page 3  This CONDITION is not met as evidenced by: o Failure to identify patients who have the potential to develop negative outcomes and failure to implement systems and interventions designated to the prevention of those negative outcomes. G140,143,168 o Failure of the governing body to assume responsibility for the overall management of the agency. G128 o Failure of the governing body to ensure that individuals appointed to the position of Administrator receive adequate orientation and training and that clear and consistent lines of authority within the agency, from the administrator down to the delivery of patient care are established. G 128, G133 o Failure to ensure that all staff hired at various levels within the agency are qualified for the assigned positions and that they receive sufficient orientation, training, and supervision to perform their job responsibilities G128, G140 o Failure of the governing body to ensure that the individual appointed to the position responsible for supervision of nursing and therapy staff (Director of Clinical Management) possesses the necessary qualifications for the position and that the employee received adequate orientation, training and supervision G138 o Failure to ensure administrative and supervisory functions are performed effectively	G 122	G122 484.14 Organization, Services and Administration Condition  Failure to identify patients who have the potential to develop negative outcomes and failure to implement systems and interventions designated to the prevention of those negative outcomes. G140, 143. 168  With respect to G140 supervision of a professional nurse, G143 coordination of care to meet the objectives of the plan of treatment and G168 skilled nursing services following systemic issues have been addressed and corrected to improve accountability of the MCP staff and clinical staff: 1.) The implementation of area teams in each branch so that it is clear to the MCP and to their staff who is the MCP they report to and to the MCP who they supervise 2.) To improve supervision a team was added to the Liverpool, Oswego and Auburn branch, so that each MCP has a smaller group of clinicians to supervise/manage and a smaller patient census per team. 3.) Reduced case manager caseloads to promote quality in patient care and documentation. This was done by hiring additional RN staff. The RN staff will be case managing between 25-30 patients. 4.) 100% review by the MCP of all SOC assessments and the POT.	5/15/09 5/27/09 5/27/09 4 on going

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G 122	<p>Continued From page 4</p> <p>and that agency policies and procedures are appropriate and implemented consistently G133,140</p> <p>o Failure to develop and implement a system which ensures that changes in patient condition are promptly identified and reported to the physician, and that priority needs are addressed, both of which are necessary to the prevention of negative patient outcomes.</p> <p>o Failure to ensure effective communication and coordination between all disciplines including supervisory staff as outlined in agency policy. G143,144</p> <p>o Failure to ensure internal quality assurance/improvement audits are of sufficient scope to identify quality of care issues, that results are trended, and that adequate plans are being developed and revised for the resolution of identified problems. G250</p> <p>The cumulative effect of these systemic problems resulted in the home care agency's failure to ensure the provision of quality health care. Additionally, this failure to provide oversight resulted in negative outcomes for seven patients: #1, 2, 6, 26, 27, 30, 37 and potential negative outcomes for the agency's entire patient population.</p> <p>On December 26, 2006 a recertification survey was completed and determined 4 Conditions were not in compliance. Although all 4 conditions were back in compliance during re-visits completed on 03/19/07 and 08/13/08, the agency failed to maintain compliance in the following areas: supervision of professional and</p>	G 122	<p>5.) SOC case conference within the first week of care to review the POC is appropriate to meet the patient's needs</p> <p>6.) The case conference process is as follows: It will be held weekly, patients will be selected by that have just been open to services (SOC); resumption of care, recertification and/or discharge; if the patients condition is unstable, fragile or requires frequent changes in the POC or multidisciplinary. Wound care conferences will occur per policy.</p> <p>Case conferences will consist of a review of patient care and coordination including but not limited to services provided; progress within the care plan; progress towards goals should the patient be discharged or recertified. The medical record will be utilized to facilitate the case conference.</p> <p>7.) The MCP will ensure follow-up visits are assigned as needed with changes in patient condition The MCP will ensure the RN/PT assess the patient and that the RN/PT, LPN/PTA practice within their scope of practice (observe and report).</p>	<p>5/21/09</p> <p>ongoing</p> <p>5/21/09</p>

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G 122	Continued From page 5 paraprofessional staff; supervision of patient care; coordination of care; identification of changes in patient condition; skilled nursing care; and evaluation of the agency's program.	G 122	8.) Due to accountability/performance issues the scheduling staff has been replaced (with the exception of two) to assist in the coordination of patient visits within the teams and case managers. The RN identifies the LPN visits and provides to the scheduler a schedule of RN and LPN visits at the SOC for that episode of care. PT identifies their visits and the visits the PTA will be making. The LPN/PTA will communicate with the RN/PT on a daily basis. This will be documented on the bottom of the visit note.	5/27/09 going	
G 128	484.14(b) GOVERNING BODY  A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.  This STANDARD is not met as evidenced by: Based on a review of 41 clinical records, 25 observational home visits, Governing Body meeting minutes dated October 21, 2008, Professional Advisory Meeting Minutes dated September 23, 2008 and December 2, 2008, the Annual Program Evaluation dated June 3, 2008 for the year 2007, and interviews with the agency Administrator, the Director of Performance Improvement, and staff at all levels within the agency, evidence is lacking in 39 clinical records and 25 observational home visits that the Governing Body effectively oversees the operation and management of the agency. Patients # 1-11, 14-41.  Failure of the Governing Body to provide adequate oversight and direction of the agency resulted in negative outcomes for seven patients: # 1, 2, 6, 26, 27, 30, 37, multiple repeat standard level deficiencies and multiple repeat condition level deficiencies as outlined in the body of this report.  Specifically, evidence is lacking that the following Governing Body responsibilities are being performed:	G 128	9.) The Governing Body will monitor the implementation of the Plan of Correction through weekly and then monthly calls with the AVP of Regulatory Affairs, the RVP and the VP of Clinical Operations. The status of compliance will be measured through chart audit results shared with the members of the call along with orientation and personnel file audits. The monitoring and current status of case manager case loads will also be presented for input and recommendations.  10.) As issues are identified field supervision will occur by the MCP/designee with the clinicians. These include but are not limited to: with lack of quality documentation and care issues; patients who have verbalized a compliant with services; New staff within 60 -90 days and existing staff will have their yearly supervisory visits per policy.	5/27/09 going	

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G 122 Continued From page 5  
paraprofessional staff; supervision of patient care;  
coordination of care; identification of changes in  
patient condition; skilled nursing care; and  
evaluation of the agency's program.

G 128 484.14(b) GOVERNING BODY

A governing body (or designated persons so  
functioning) assumes full legal authority and  
responsibility for the operation of the agency.

This STANDARD is not met as evidenced by:  
Based on a review of 41 clinical records, 25  
observational home visits, Governing Body  
meeting minutes dated October 21, 2008,  
Professional Advisory Meeting Minutes dated  
September 23, 2008 and December 2, 2008, the  
Annual Program Evaluation dated June 3, 2008  
for the year 2007, and interviews with the agency  
Administrator, the Director of Performance  
Improvement, and staff at all levels within the  
agency, evidence is lacking in 39 clinical records  
and 25 observational home visits that the  
Governing Body effectively oversees the  
operation and management of the agency.  
Patients # 1-11, 14-41.

Failure of the Governing Body to provide  
adequate oversight and direction of the agency  
resulted in negative outcomes for seven patients:  
# 1, 2, 6, 26, 27, 30, 37, multiple repeat standard  
level deficiencies and multiple repeat condition  
level deficiencies as outlined in the body of this  
report.

Specifically, evidence is lacking that the following  
Governing Body responsibilities are being  
performed:

G 122

G 128

11.) The Administrator/DPS will meet  
with the MCP staff bi-weekly and hold MCP  
conference calls weekly in-between. These  
meetings will address care and  
documentation issues; staffing needs;

these meetings in addition to the morning  
meetings. These meetings will be  
documented.

12.) Revamped orientation program to  
ensure that new clinicians have the time to  
adapt to homecare before given a full  
assignment. They will gradually increase  
their case load based on their ability to  
complete quality documentation and care.  
Their skills are verified by the educator and  
their preceptor in the field. The MCP will  
meet with the orientee weekly once on her  
team.

Revised PI program and PAC to include the  
following measures:

- a.) Clinical Record Review results
- b.) New orientation chart audits
- c.) Personnel file audits
- d.) Quarterly policy reviews
- e.) RN case management case load  
reports

f.) Results of the monthly team audits  
g.) Adverse events  
h.) Trends of complaints, incidents and  
infections

i.) Inclusion of the AVP of Regulatory  
Affairs as a member of the PAC committee.

(a member of the governing  
body)

Governing Body weekly calls with the VP of  
Clinical Operations; the AVP of Regulatory  
Affairs; the RVP of operations will be held

with the Administrator until the conditions are  
lifted and then become monthly. The

members of the calls will be sent Chart audit  
results; orientation chart audit results and  
case manager case load reports.

acceptable 5/15/09  
Paula Williams, LWT#45C

14.

5/27/09

5/19/09

4/21/09

going

#2  
page  
4

The Administrator is responsible for all of the  
above outcomes.

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G 128	<p>Continued From page 6</p> <p>o Exercising its ability for the overall management and supervision of the agency. Evidence is lacking that the Governing Body understood it's responsibility to provide oversight and direction specific to the agency. Specifically, the Governing Body minutes dated October 21, 2008 for a meeting at the corporate level lack a specific reference to the CHHA located in Liverpool, New York and and its two branches located in Oswego, New York and Auburn, New York. The minutes contain a general statement: "No substantive recommendations had been made for Governing Body consideration. Where noted, office administrators and staff will respond to recommendations within their respective markets".</p> <p>o Ensuring that supervision of all patient care is provided and readily available. Specifically, that supervisors are ensuring that: case coordination and case management are being performed; patients receive the necessary services based on a professional assessment of the patient's needs; plans of care are completed and followed; changes in patient condition are identified and reported to the physician; nursing assessments are complete and accurate; and nurses are qualified, trained, and supervised. G140, 143, 144, 158, 159, 171, 172</p> <p>Evidence is lacking that the administrator was given the authority to provide oversight of the entire agency operations and the Director of Clinical Management lacked the clinical experience to oversee the clinical operations of the agency.</p> <p>Specifically, on 02/09/09 the surveyor interviewed the individual who was functioning as the</p>	G 128	<p>G Tag #128 484.14(b) Governing Body assumes full legal authority and responsibility for the operations of the agency.</p> <p>Governing Body Calls: the AVP of Regulatory Affairs and the VP of Clinical Operations along with the RVP of Operations and the Administrator are conducting weekly conference calls. The calls will review progress with the plan of correction. The calls will review the plan of correction. The governing body will assist in providing any support needed to the ensure quality documentation, care and services for our patients. The calls will begin on April 21, 2009. Governing body calls will continue weekly until the conditions are lifted. They will then become monthly through 2009.</p> <p>Monthly chart audit results, orientation audits and case manager case load status will be shared with the governing body calls for their input and recommendations. The governing body will review and approve action plans. The Governing Body calls are documented by the Governing Body and sent to the Administrator.</p> <p>All aspects/staff within the three branches report through a MCP/designee to the Administrator/DPS who has the responsibility to direct and organize the branches' on going functions. The DPS will report directly to the Administrator.</p> <p>The administrator is a liaison to the governing body and reports through weekly/monthly conference calls.</p>	<p>5/15/09 acceptable</p> <p>Paula Williams RWH</p> <p>5/21/09</p> <p>going</p> <p>5/27/09</p> <p>on going</p> <p>5/27/09</p>

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G 128	<p>Continued From page 7</p> <p>Administrator from October 30, 2008 until February 4, 2009. She stated that all clinical services were being supervised by a Corporate Vice President, and that she had no role for clinical oversight of the agency. The Corporate Vice President was located in Binghamton, NY and had oversight of multiple agencies within New York State. The Administrator stated that until December 18, 2008 she did not supervise the Director of Clinical Management (DCM), but instead, the DCM was supervised by a corporate Vice President. The Administrator further stated that the Director of Clinical Management implemented several changes, autonomously, and failed to follow established agency policy; and that the Administrator had no authority over the DCM. This reporting structure was changed on December 18, 2008, at which time the DCM reported to the Administrator. Furthermore, the surveyor determined through a review of the resume for the Director of Clinical Services, that she lacked the required experience for the position. The corporation terminated the DCM on January 19, 2009. The surveyor was notified in writing on February 9, 2009 that the agency's Director of Performance Improvement was reassigned to the position of DCM, designated in an acting capacity because she, too, lacked the qualifications for the position.</p> <p>The Governing Body also failed to ensure continuity with respect to administration of the agency. Specifically, four different Administrators and three different Directors of Clinical Management were appointed to these positions since August 13, 2008, the date of the prior New York State Department of Health recertification survey. On February 9, 2009, the agency provided written notification to the New York State</p>	G 128	<p>The AVP of Regulatory Affairs will become of member of the PAC committee. He will join either via conference call or in person. He will receive a copy of the PAC meeting minutes. <i>He is the governing body representative</i></p> <p>Any Governing Body recommendations will be integrated into the action plan developed with the PAC.</p> <p>Hiring for management roles (DCM, MCP, and Administrator) will follow the company and state guidelines and experience /education requirements. It will be the AVP/designee responsibility to ensure only qualified professionals are hired. This will be evident by the AVP signature within the interview process.</p>	<p>5/19/09</p> <p>5/27/09</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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G 128	Continued From page 8 Department of Health that a new Administrator, who is the Regional Director of Clinical Operations, was reassigned to the CHHA. The Administrator from October 30, 2008 until February 4, 2009 was reassigned to the position of Business Manager.  o Ensuring internal agency audits are of sufficient scope to identify quality of care issues and deficient practices, and that resolutions are developed and implemented. G250  o Ensuring that the agency's Professional Advisory Committee reviews and revises agency policies and procedures, as needed and at least annually. G153, 248  o Ensuring that the agency is consistently functioning in full compliance with all applicable rules and regulations as outlined in this report.	G 128			
G 132	484.14(b) GOVERNING BODY  The governing body oversees the management and fiscal affairs of the agency.  This STANDARD is not met as evidenced by: See G128	G 132			
G 133	484.14(c) ADMINISTRATOR  The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.  This STANDARD is not met as evidenced by:	G 133			



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G 133	<p>Continued From page 9</p> <p>Based on a review of 41 clinical records, and interviews with the present and previous agency Administrators, interviews with the previous and acting Director of Clinical Management, interviews with agency staff, review of personnel records and agency policies and procedures, and review of Professional Advisory Committee and Governing Body minutes, evidence is lacking in 39 records that the Administrator effectively oversees the operation and management of the agency.</p> <p>Patients #1-11, 14-41.</p> <p>Failure of the agency Administrator to provide adequate oversight and direction of the agency resulted in negative patient outcomes for seven patients: #1, 2, 6, 26, 27, 30, 37, multiple repeat standard and condition level deficiencies, and creates the potential for agency wide negative patient outcomes.</p> <p>Specifically, evidence is lacking the following responsibilities of the Administrator are being performed:</p> <ul style="list-style-type: none"> <li>o Ensuring the Professional Advisory Committee annually reviews the agency's administrative and clinical policies G153</li> <li>o Ensuring an effective plan is implemented to maintain compliance with 42 CFR 484. Specifically, during a recertification survey dated 12/28/06, the agency was found out of compliance with the following four Conditions of Participation: Organization, Services, and Administration; Acceptance of Patients, Plan of Care, and Medical Supervision; Skilled Nursing Services; and Evaluation of the Agency's Program. Although the agency was able to</li> </ul>	G 133	<p><i>Governing Body Calls</i></p> <p>Implementation of the Plan of Correction will be monitored through weekly and then monthly calls with the AVP of Regulatory Affairs, the RVP and the VP of Clinical Operations. The status of compliance will be measured through chart audit results shared with the members of the call along with orientation and personnel file audits. The monitoring and current status of case manager case loads will <sup>also</sup> be presented for input and recommendations.</p> <p>Revised PI program and PAC to include the following measures:</p> <ul style="list-style-type: none"> <li>a.) Clinical Record Review results</li> <li>b.) New orientation chart audits</li> <li>c.) Personnel file audits</li> <li>d.) Quarterly policy reviews</li> <li>e.) RN case management case load reports</li> <li>f.) Results of the monthly team audits</li> <li>g.) Adverse events</li> <li>h.) Trends of complaints, incidents and infections</li> <li>i.) Inclusion of the AVP of Regulatory Affairs as a member of the PAC committee.</li> </ul> <p>The administrator is responsible for compliance with this standard. Lack of compliance will lead to disciplinary activities.</p>	<p>5/18/09 + on going</p>

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G 133	<p>Continued From page 9</p> <p>Based on a review of 41 clinical records, and interviews with the present and previous agency Administrators, interviews with the previous and acting Director of Clinical Management, interviews with agency staff, review of personnel records and agency policies and procedures, and review of Professional Advisory Committee and Governing Body minutes, evidence is lacking in 39 records that the Administrator effectively oversees the operation and management of the agency.</p> <p>Patients #1-11, 14-41.</p> <p>Failure of the agency Administrator to provide adequate oversight and direction of the agency resulted in negative patient outcomes for seven patients: #1, 2, 6, 26, 27, 30, 37, multiple repeat standard and condition level deficiencies, and creates the potential for agency wide negative patient outcomes.</p> <p>Specifically, evidence is lacking the following responsibilities of the Administrator are being performed:</p> <ul style="list-style-type: none"> <li>o Ensuring the Professional Advisory Committee annually reviews the agency's administrative and clinical policies G153</li> <li>o Ensuring an effective plan is implemented to maintain compliance with 42 CFR 484.</li> </ul> <p>Specifically, during a recertification survey dated 12/28/06, the agency was found out of compliance with the following four Conditions of Participation: Organization, Services, and Administration; Acceptance of Patients, Plan of Care, and Medical Supervision; Skilled Nursing Services; and Evaluation of the Agency's Program. Although the agency was able to</p>	G 133		

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G 132	484.14(b) GOVERNING BODY  The governing body oversees the management and fiscal affairs of the agency.  This STANDARD is not met as evidenced by: See G128	G 132			
G 133	484.14(c) ADMINISTRATOR  The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.  This STANDARD is not met as evidenced by:	G 133			

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5/15/09 acceptable Paul Williams RN

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G 133	<p>Continued From page 10</p> <p>demonstrate correction of the four Condition level deficiencies on 3/19/07, repeat standard level deficiencies were cited on 8/13/08. Multiple repeat standard and condition level deficiencies are cited within the body of this report. The same four Conditions cited on 12/28/06 recertification survey are out of compliance which demonstrates the failure to maintain compliance. Evidence is lacking that the Administrator ensured that the agency continued to implement the plans of correction submitted to the New York State Department of Health in response to these respective surveys.</p> <p>o Ensuring internal quality assurance audits are provided to the governing body and that an effective plan is developed to resolve areas in need of improvement. G250</p> <p>o Ensuring the provision of adequate supervision of patient care and skilled nursing staff. Specifically, that supervisors are ensuring that: case coordination is being performed; plans of care are complete and being implemented; changes in patient condition are being reported to the physician; nursing assessments are complete and accurate; and nurses are oriented, trained and evaluated as clinically competent. G134</p> <p>On February 9, 2009, the surveyor interviewed the employee who was functioning as the Administrator from 10/30/08 until 02/04/09. The Administrator stated that she did not supervise the Director of Clinical Management (DCM) until 12/18/08. The DCM reported to a corporate Vice President during this time period. The Administrator stated that until 12/18/08, she had no role in the clinical oversight of the agency.</p>	G 133	<p>1.) The implementation of area teams in each branch so that it is clear to the MCP and to their staff who is the MCP they report to and to the MCP who they supervise</p> <p>2.) To improve supervision a team was added to the Liverpool, Oswego and Auburn branch, so that each MCP has a smaller group of clinicians to supervise/manage and a smaller patient census per team. As team census grows over 125-150 a QA coordinator will be added to the team.</p> <p>3.) Reduced case manager caseloads to promote quality in patient care and documentation. This was done by hiring additional RN staff. The RN staff will be case managing between 25-30 patients.</p> <p>4.) 100% review by the MCP of all SOC assessments and the POT to ensure accuracy and that the POT is appropriate based on the assessment. This will be documented on the SOC tool.</p> <p>5.) SOC case conference within the first week of care to review the POC is appropriate to meet the patient's needs</p> <p>6.) The case conference process is as follows: It will be held weekly, patients will be selected by that have just been open to services (SOC); resumption of care, recertification and/or discharge; if the patients condition is unstable, fragile or requires frequent changes in the POC or multidisciplinary. Wound care conferences will occur per policy.</p> <p>Case conferences will consist of a review of patient care and coordination including but not limited to services provided; progress within the care plan; progress towards goals should the patient be discharged or recertified. The medical record will be utilized to facilitate the case conference.</p>	<p>5/27/09</p> <p>5/27/09</p> <p>5/27/09</p> <p>5/27/09</p> <p>5/27/09</p> <p>5/27/09</p>

*5/27/09 acceptable*  
*Paula Williamson-Huse*

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G 133	Continued From page 11 o Ensuring that safe discharge plans are being developed and approved by the physician, prior to patient discharge.	G 133	The Administrator/DPS will meet with the MCP staff bi-weekly and hold MCP conference calls weekly in-between. These meetings will address care and documentation issues; staffing needs; educational needs of the team and audit and employee compliance outcomes. Complaints and Incidents will be reviewed at these meetings in addition to the morning meetings.		5/27/09 + on going
G 134	484.14(c) ADMINISTRATOR  The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.  This STANDARD is not met as evidenced by: Based on review of 24 personnel records of skilled nurses (RNs and LPNs), review of the agency's Orientation policy, and interviews with 6 skilled nurses, the Area Staff Development Specialist and acting Administrator, evidence is lacking in 11 records that the administrator has ensured that staff complete the agency orientation process. (Employees B, D, F, G, J, K, N, X, Y, BB, DD)  In addition, 7 of 24 skilled nursing personnel records lacked a complete assessment of skills prior to the provision of patient care. (Employees A, C, J, AA, EE, FF, GG)  Failure to provide a complete orientation process and adequately assess nursing skills prior to patient contact has the potential for negative patient outcomes.  Specifically, the lack of orientation is as follows:  - Personnel records for 3 registered nurses lacked any evidence of orientation. Employees Y, BB and DD.	G 134	Orientation has been evaluated and the changes to this process are as follows: Orientation has three phases: didactic instructions/ revisits with a preceptor, OASIS training and completion of OASIS assessments with their preceptor; case management and MCP managed case loads to be specific to the clinicians ability to manage patients.  Effectiveness of orientation will be measured through a chart audit of 5 records once they begin case management. The DCM/designee will be responsible to perform these audits. The DCM will work with the MCP to ensure continued mentoring or a decision will be made as the clinician's ability to perform and document homecare services.  The MCP is the over-all "preceptor" and will review the documentation and meet with the clinicians weekly. <i>The MCP therefore is responsible for the completion of Orientation.</i>		5/27/09 + on going

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G 134	<p>Continued From page 12</p> <ul style="list-style-type: none"> <li>- Evidence of any orientation was lacking for the Director of Clinical Management (hired 08/13/08 to 01/19/09). Specifically, the personnel record only contained documentation of meeting other employees throughout the organization. There was no documentation of orientation to her role as Director of Clinical Management. Employee M</li> <li>- In 3 of 6 personnel records for employees assigned as Managers of Clinical Practice (Supervising Nurses), evidence is lacking of a complete orientation. Specifically, there is no evidence that each employee was oriented to their role as Managers of Clinical Practice. Employees G, J, K.</li> <li>In 4 of 10 personnel records reviewed for registered nurses, evidence is lacking that the orientation was completed and documented. Employees B, D, N, and X.</li> <li>In 6 of 16 personnel records reviewed for RNs and LPNs, evidence is lacking that the following skills competencies were assessed prior to patient assignment:</li> <li>- Employee A (an LPN)- lacked competency in Gastrointestinal/Nutrition and Urinary Care and Pediatric Procedures these sections were left blank.</li> <li>- Employee FF (an LPN) - lacked competency in Gastrointestinal/Nutrition, Endocrine, Urinary Care, Pediatric Procedures these sections were left blank.</li> <li>- Employee GG, (an LPN) lacked competency in Dressing and Wound Care, Cardiopulmonary Care; Gastrointestinal/Nutrition; Endocrine;</li> </ul>	G 134	<p>4.) A clinical skills fair-is being scheduled will take place by May 22, 2009. The fair will be provided by the educator. New skills demonstrated will be signed and updated on the skills checklist. The skills checklist will be kept in a binder with the MCP so that as patient needs are identified the MCP can match the nurse with those skills to the patient.</p> <p>5.) Outcomes of the orientation chart audits performed by the MCP/Designee will be reviewed monthly by the Administrator/DPS and discussed with the educator and also at the weekly MCP meetings. The results will be presented at the quarterly PAC meetings for additional recommendation for improvement as necessary.</p> <p>The following employees have had the following corrected:</p> <p>Employee Y and BB have resigned Employee DD: the educator She Will need to recreate her orientation materials. To be completed by May 15, 2009.</p> <p>The DCM was termed. Employee K completed checklist is in the file Employee D checklist completed Employee G covering DCM role presently, is not remaining in the role. Employee B checklist was completed, just not in folder, present currently. Employee B check list in folder from 2006 Employee N checklist was in file Employee X resigned</p>	<p>5/27/09</p> <p>5/27/09</p> <p>5/15/09</p>

5/15/09 acceptable  
Paula Williams-RW HMC

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G 134	<p>Continued From page 13</p> <p>Medication Administration; Pain Management; Urinary Care; and Fall Prevention Management, these sections were left blank. Additionally, the competency evaluation for fingerstick PT/INR and glucometer was completed an LPN.</p> <ul style="list-style-type: none"> <li>- Employee AA, (an RN) lacked competency in Gastrointestinal/Nutrition and Urinary Care these sections were left blank.</li> <li>- Employee EE, (an RN), lacked competency in Gastrointestinal/Nutrition and Urinary Care, and Infusion Therapy these sections were left blank.</li> <li>- Employee C, (an RN), lacked competency in Gastrointestinal/Nutrition and Urinary care. Infusion Therapy and Pediatric Procedures, these sections were left blank.</li> </ul> <p>Additionally, evidence is lacking that the administrator is ensures that annual performance evaluations are complete.</p> <p>Based on review of 16 personnel records of professional and para-professional staff who have been employed for 12 or more months, and interviews with the Area Staff Development Specialist and acting Administrator, evidence is lacking in 6 records of an annual performance assessment. (Employees D, E, P, Q, R, T)</p> <p>Failure to conduct an annual assessment of each employees' performance and effectiveness may lead to unmet patient needs and/or negative patient outcomes.</p> <p>Specifically:</p> <p>Employee D is a Clinical Account Executive</p>	G 134	<p>Employee A nutritional assessment was signed off 8/26/08 No other competencies were required.</p> <p>Employee FF Nutritional assessment was signed off 8/26/08. Intermittent catheterizations signed off 8/26/08.</p> <p>Employee GG skills observed by ASDS on supervisory visit 1/19/09. Skills list updated.</p> <p>Employee AA no completions were required.</p> <p>Employee EE No completions were required, does not perform infusion.</p> <p>Employee C No competencies were required, does not perform infusion.</p> <p>Employee D evaluation to be completed by May 15, 2009</p> <p>Employee E resigned</p> <p>Employee P completed 12/26/08</p> <p>Employee Q completed 12/18/08</p> <p>Employee R completed 1/30/09</p> <p>Employee T completed 5/6/08</p> <p>A RC 2 position has been hired whose responsibilities are the personnel files. A monthly report will be run of all upcoming performance evaluations and tracked by the RC 2. Reviews not completed timely will be shared with the Administrator who will ensure the evaluations are completed.</p>		

5/15/09 Paula J. Williams  
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G 134	Continued From page 14 whose date of hire was 5/1/00. The most recent performance assessment in this personnel record was completed in 2005.  Employee E is a Registered Nurse whose date of hire was 1/8/07. The most recent performance assessment in this personnel record was dated 1/8/08. The record lacked a performance assessment for 2009.  Employee P is a Speech-Language Pathologist whose date of hire was 12/16/07. The personnel record lacked evidence of any performance assessments completed since the date of hire.  This information was reviewed with the acting Administrator on 02/11/09. No further information was provided.	G 134			
G 138	484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE  The skilled nursing and other therapeutic services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least 1 year of nursing experience and is a public health nurse).  This STANDARD is not met as evidenced by: Based on a review of the personnel file for the employee functioning as Director of Clinical Management (DCM) from September 15, 2008 until January 19, 2009 and the employee "acting" in the role of Director of Clinical Management as of February 4, 2009, and interviews with the previous and current Administrators, evidence is lacking that the agency appointed a qualified, experienced registered nurse to be responsible	G 138 <i>5/15/09 acceptable Provider</i>	G138 484.14 (d) Supervising Physician or Registered Nurse  Hiring for management roles (DCM, MCP, and Administrator) will follow the company and state guidelines and experience /education requirements. It will be the AVP/designee responsibility to ensure only qualified professionals are hired.  To address the needs of the new MCP staff a clinical management course has been scheduled for the week of May 11.2009. It is a three day course. This course includes but not limited to: 1.) Concepts of PI: adverse events; Medicare outcome reports; how to complete a chart audit; how to handle a complaint, incidents; billing compliance audits; how to run and analyze patient management reports; how to review an OASIS and POT.		<i>5/13/09</i>

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G 138	Continued From page 15 for supervision of all skilled nursing and therapeutic services.  Specifically, both the previous and acting DCM lack evidence of home care experience. Furthermore, evidence is lacking that the agency ensured that each of these candidates were oriented to the responsibilities of the position.  Failure to ensure that the supervising nurse meets the qualifications of the position resulted in negative outcomes for seven patients: # 1, 2, 6, 26, 27, 30, 37 and the potential for negative outcomes for the entire patient population.	G 138	Outcomes of the orientation chart audits performed by the MCP/Designee will be reviewed monthly by the Administrator/DPS and discussed with the educator and also at the weekly MCP meetings. The results will be presented at the quarterly PAC meetings for additional recommendation for improvement as necessary. The current Administrator/DPS meets the criteria for the position. The search continues and was elevated to the AVP of Recruiting level for a qualified DPS. The company has even approved paying for relocation if necessary to find the right qualified candidate for this position. The candidate when identified will be interviewed not only by the Administrator but also the VP of Clinical Operations.		5/27/09
G 140	484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE  Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).  This person, or similarly qualified alternate, participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.  This STANDARD is not met as evidenced by: Based on a review of 41 clinical records, interviews with the previous and current Administrator, interviews with the previous and acting Director of Clinical Management (DCM), review of agency policies and procedures, and review of personnel files, evidence is lacking in 39 records that the following supervisory responsibilities are being performed:	G 140	The Administrator/DPS is responsible for compliance with the orientation process,  and hiring of Competent staff that meet the Criteria /standards of the position.		

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G 140	<p>Continued From page 16</p> <ul style="list-style-type: none"> <li>o Ensuring that nurses providing care are qualified, oriented to the position, and have been evaluated as competent in the skills they are assigned to perform independently. Specifically, 6 out of 6 skilled nurses hired within 6 months prior to the survey lack evidence of either a completed orientation program or a skills competency evaluation. See G 134</li> <li>o Ensuring that nurses are assigned tasks that are only within their allowable scope of practice per New York State Education Department Licensure requirements. Specifically, the agency is routinely assigning Licensed Practical Nurses (LPN) to visit patients who have reported changes in condition and who require assessment. Patient assessment is beyond the LPN scope of practice. As outlined in Title VIII Education Law, Article 139 - Nursing</li> <li>o Ensuring that Supervising Nurses are aware of the current status of each patient; that skilled nurses are providing comprehensive patient assessments and reassessments; that the plan of care developed is comprehensive and meets all patient needs; that the physician is consulted when changes in the patient's condition occur. G144, 159, 164, 171, 172</li> <li>o Ensuring that coordination/case management is being performed consistently and that all pertinent patient information is communicated to all individuals providing care G143, 144</li> <li>o Ensuring that the plan of care is being followed and that patients are not discharged from service prior to physician consultation/approval and prior to the development of a safe and adequate</li> </ul>	G 140	<p>All new clinical staff will be trained through the newly revised clinician associate orientation and follow the checklist of their discipline specific skill and requirements in their entirety.</p> <p>With joint visits with their preceptor skills will be validated as observed by the preceptor. In addition as new skills need to be observed, it will be scheduled with a like discipline already providing the skilled care for demonstrated competency and ability to perform that skill set. The skills checklist will be updated as new skills are verified. In addition a skill fair is being scheduled by May 22, 2009. <i>Current staff is included in this as well</i></p> <p>Staff was in-serviced on care coordination on:</p> <p>Liverpool: 3/31/09 Auburn: 3/24/09 Oswego: 4/7/09</p> <p>An in-service on scope of practice is scheduled for:</p> <p>Liverpool: 5/21/09 Oswego: 5/19/09 Auburn: 5/20/09</p> <p>OASIS training classes are provided monthly; This is training in how to assess the patient and complete an OASIS assessment. From this assessment how to identify patient needs and create a POC.</p>	

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G 140	Continued From page 17 discharge plan. G158, 159, 164  Failure to provide adequate supervision has led to unmet patient needs, negative outcomes for seven patients: #1, 2, 6, 26, 27, 30, 37 and the potential for negative outcomes for the agency patient population.	G 140	Discharge Planning In-service is scheduled for: Liverpool: 5/21/09 Auburn: 5/20/09 Oswego: 5/19/09		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES  All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.  This STANDARD is not met as evidenced by: Based on a review of 37 clinical records (patients 1-10, 12-28, 30-41) for patients receiving skilled nursing and at least one other service, agency policies and procedures, and interviews with the acting Administrator and Supervising Nurses, evidence is lacking in 17 clinical records, that skilled nurses are functioning in the role of case management/coordination. Patients # 1-4, 6, 8, 11, 15, 19, 23, 24, 27, 30, 31, 34, 36, 37.  Although each patient is assigned an RN case manager who is responsible for patient care and supervision, the case manager failed to ensure the following:  - significant information is being exchanged between all individuals responsible for developing and implementing the plan of care.  - physicians are alerted promptly to changes in the patient's condition which may warrant immediate action or a modification in the plan of	G 143	The MCP reviews 100% of the SOC Assessment and the POC. In addition case conferences occur at the SOC, resumption of care, recertification, and prior to discharge. Case conferences occur with wound care patients and with changes in the patient's condition. Evidence of these conferences will be present in the medical record.  In order to facilitate care coordination field staffs were assigned to teams. In this team each 2RN staff has an assigned LPN to be a part of the care team providing care to the patient. The PT staff is assigned a PTA in the same model. The RN and PT are responsible to assign visits to the LPN/PTA staff. The LPN/PTA will call and update the case manager with the visits made daily. This will be documented in the medical record. The MCP of the team is responsible to facilitate this model.		5/27/09  5/27/09

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G 143	<p>Continued From page 18 care.</p> <p>- case managers are providing communication and oversight to Licensed Practical Nurses (LPNs) to ensure that the plan of care is implemented and changes in the patient's status is reported to the physician.</p> <p>Failure to ensure that skilled nurses are functioning in the role of case management/coordination has resulted in negative outcomes for patients # 2, 26 and the potential for negative outcomes for the agency's entire patient population.</p> <p>1. Patient #26 was admitted to the agency on 12/10/2004 with diagnoses of Alzheimer's disease and urinary incontinence requiring an indwelling urinary catheter. The plan of care for the certification period 11/19/08 to 01/17/09 stated skilled nursing visits one (1) time a month for 2 months to assess the patient, and change the urinary catheter; home health aide visits 3 times a week for 1 week, then 5 times a week for 7 weeks.</p> <p>Evidence is lacking the RN case manager recognized changes in the patient's condition, reported these changes to the physician, and provided adequate supervision and oversight of the LPN. As a result of the RN's failure to provide adequate case coordination, the patient's condition deteriorated, and the patient was transported by ambulance to the hospital and subsequently died.</p> <p>Specifically, the RN case manager visited the patient twice weekly from 11/28/08 to 12/12/08. During these visits the skilled nurse documented</p>	G 143	<p>The MCP and RN/PT case manager is to be contacted for changes in patient condition. The MCP will ensure that a follow-up visit for assessment has been scheduled by the case manager. The case manager is to contact the MCP with the outcome of that visit. The MCP or patient case manager will contact the MD.</p> <p>Coordination of care in-services were completed on: Liverpool: 3/31/09 Auburn: 3/24/09 Oswego: 5/19/09</p> <p>The Administrator/DPS is responsible for the above coordination of care. This will be monitored for continued compliance with the Clinical Record Review. Disciplinary action will take place up to and including termination for staff not compliant with this regulation. Documentation of this disciplinary process will be filed in the personnel file.</p>	5/27/09

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G 143	<p>Continued From page 19</p> <p>the following changes in the patient's condition that were not reported to the physician or communicated to all staff responsible for providing care.</p> <p>On 11/28/08, 11:05 am, the RN case manager visited the patient to complete her monthly skilled nursing assessment and documented the following change in condition: heart rate was elevated to 100 beats per minute (bpm) (the patient's heart rate documented during monthly assessment visits from 07/2/08 to 11/14/08 ranged from 64 to 88 bpm); the patient's husband was having difficulty feeding the patient and the patient's urine was "more amber than usual". The RN failed to report the patient's increased heart rate and decreased ability to consume food to the physician.</p> <p>- on 12/01/08, the RN case manager documented that the patient's heart rate was now elevated to 108 bpm and respiratory rate was increased to 24. The RN case manager again documented that the patient had "darker" amber urine. The RN case manager failed to communicate the elevated heart rate and increased respiratory rate to the physician.</p> <p>On 12/01/08, at 7:30 pm the RN case manager (who was on-call) received a call from the patient's husband stating that the patient would not wake up. The RN case manager visited the patient and documented that the patient's heart rate was 104 bpm. and she was no longer alert as per the 11/14/08 assessment. Specifically, the RN case manager documented that the patient was responsive only to tactile stimuli by opening her eyes. The RN case manager also documented that the patient's urine output was</p>	G 143		

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G 143	<p>Continued From page 20</p> <p>very low at 150 cc amber urine since 11 am. The skilled nurse documented that she attempted to contact the physician but was unable to reach him. At the bottom of the 12/01/08 skilled nursing visit note, the skilled nurse documented that on 12/02/08 that she called the physician and spoke to a nurse, however, the skilled nurse failed to document the details of what was discussed with the physician's nurse. The RN case manager failed to conduct a visit until 3 days later.</p> <p>On 12/04/08, the RN case manager documented a blood pressure of 74/64; that the blood pressure was low because of a poor blood pressure cuff fit; that the urine output was 200 cc, and contained flecks of red. Although the skilled nurse documented that she reported the patient's blood pressure, blood in urine and urine output to the physician, there was no documented response from the physician, and no evidence that the skilled nurse recognized the need to reassess the patient's blood pressure with a different blood pressure cuff to ensure accuracy of the blood pressure.</p> <p>An interview with the nurse at physician's office was completed by the surveyor on 02/25/09 at 2:30 pm to determine the extent of the information provided to the physician regarding the patient's condition. The physician's nurse told the surveyor that she looked in the patient's record and in the computerized phone log for a record of calls from the home care nurse. The only documented information was on 12/04/08 was an "FYI" regarding the patient's decreased urine output. The physician's nurse stated that they were not informed about the decreased blood pressure.</p>	G 143		

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G 143	<p>Continued From page 21</p> <p>The patient was not reassessed until 4 days later on 12/08/08. On 12/08/08 a different RN visited the patient and documented the following inconsistent findings: the nurse documented that the patient was unresponsive and that she was being fed by her husband.</p> <p>There was no evidence that the RN case manager communicated with the skilled nurse before or after the visit to discuss the patient's deteriorating condition. As a result of the lack of communication, the skilled nurse failed to assess the following: the patient's intake, skin turgor, mucous membranes and urine output to determine if the patient had increased symptoms of dehydration. Additionally, the skilled nurse failed to report the patient's decrease in responsiveness to the RN case manager or physician. The patient was never reassessed by an RN and was not visited by the LPN until 4 days later on 12/12/08.</p> <p>On 12/12/08, at 4:45 pm, the LPN visited the patient and documented that the patient was unresponsive, urine was dark amber, had a temperature of 99.1 and that she was "unable to hear" the patient's blood pressure. There was no evidence that the LPN reported the inability to hear the patient's blood pressure and low grade fever to the RN case manager or the physician.</p> <p>On 12/16/08, the patient was transported to the emergency department by ambulance and died.</p> <p>Although there is a document labeled a "late entry" note dated 12/17/08 which stated the following: "spoke to the nurse at MD office, unable to hear blood pressure at this time VS (vital signs) otherwise stable no change in orders</p>	G 143			



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G 143	<p>Continued From page 22.</p> <p>given", the surveyor contacted the physician's office on 02/25/09 at 2:30 pm to verify the information documented by the LPN in the late entry note. The nurse at the physician's office informed the surveyor that they had no record of a call from this agency on 12/12/08 and told the surveyor that "if they (the MD office) had received that information (unable to hear a blood pressure) they would have requested another visit be completed and that they would have documentation of the call".</p> <p>This record was reviewed with the Director of Clinical Management and Administrator 01/14/09 and with the acting Administrator and the acting Director of Clinical Management on 03/16/09. No further information was provided. The Director of Clinical Management stated that the agency reviewed the circumstances surrounding the patient's death and found no significant issues with the nursing care. The Director of Clinical Management did not address the issues regarding assignment of an LPN to provide assessments and the lack of LPN communication with the Supervising Nurse to report the inability to hear a blood pressure. The Director of Clinical Management also stated that the LPN did report the blood pressure issues to the physician and referred to the late entry note dated 12/17/08.</p> <p>2. Patient #2 was admitted to the agency 11/22/08 following an open reduction internal fixation of a hip fracture and a history of type II diabetes, hypertension, and pernicious anemia. The plan of care included: skilled nursing services for 3 times a week for 1 week and 2 times a week for 1 week to assess and instruct in medication management and compliance; physical therapy services 4 times a week for 1 week and 3 times a</p>	G 143	<p>PT/INR: each visit note should reflect that the values were communicated via T.C. at the time of the visit to the MCP in the office.</p> <p>The MCP will document the levels and the Coumadin dose the patient is on and then call in the levels to the MD office and fax in the results to the physician. The MCP will document all of this information on a separate form.</p> <p>Patient #2 Due to the care coordination issues identified with this patient, the PT/INR process has been updated. A conference call was completed with the branches on the new process on: April 7, 2009. Pt discharged.</p>	5/27/09	

5-15-09  
acceptable  
Paula J. Williams

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G 143	<p>Continued From page 23</p> <p>week for 2 weeks to provide therapeutic exercises, and obtain a PT/INR (blood test to monitor the effectiveness of anticoagulant therapy) on Mondays and Thursdays.</p> <p>There is no evidence that the RN case manager coordinated with the physical therapist in the development of the plan of care and discussed possible changes in the plan of care related to the patient's medication non-compliance. This lack of communication among the physical therapist, physical therapy assistant and the RN case manager resulted in a negative outcome for the patient and admission to the hospital for emergent care.</p> <p>Specifically, the failure to communicate findings include the following:</p> <ul style="list-style-type: none"> <li>o Both the RN case manager and the physical therapist completed initial assessments on 11/22/08. During the initial physical therapy assessment visit conducted, the physical therapist documented that the patient had a language barrier and that the daughter assists with interpretation. The RN case manager failed to identify this crucial patient need and the physical therapist did not discuss the initial assessment findings with the nurse. The lack of communication between the RN case manager and the physical therapist resulted in failure to develop a coordinated plan which included assurance that an interpreter was available during patient visits conducted by agency staff.</li> <li>o on 11/24/08, at 2 pm, the physical therapy assistant (PTA) visited the patient to obtain a PT/INR. The PTA documented that she reported to the physician that the "patient was not taking</li> </ul>	G 143			

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G 143	<p>Continued From page 24</p> <p>Coumadin (anticoagulant)" and that the physician wanted to increase the patient's Coumadin dosage. The clinical record contained a case communication note dated 11/24/08 from the physical therapist documenting receipt of a call from the PTA that she did not see Coumadin in the pill box, and could not determine from the patient or caregiver if the patient was taking her medication correctly. The physical therapist also documented calling the RN case manager to notify her of the medication issue. There is no evidence that the RN case manager developed a coordinated plan to ensure that the patient was correctly taking her medication and that the physician was updated.</p> <p>Specifically, although the PTA visited the patient on 11/25/08, evidence is lacking that the skilled nurse visited the patient until 11/26/08 to assess the patient's medication compliance.</p> <p>o on 11/26/08 a different RN visited the patient and documented that the medications were discussed with the patient's daughter and family. This skilled nurse documented that she discussed the patients incorrect use of coumadin with the physical therapist. Evidence is lacking, however that a plan was coordinated with the physical therapist, physician, the RN case manager and the primary care giver that addresses the patient/caregivers need for increased supervision of medications including Coumadin changes.</p> <p>o on 11/28/08, the PTA visited the patient to obtain the results of the patient's blood test. The PTA documented that the patient's blood pressure was elevated and that she woke up with a headache. On her visit note, the PTA documented that she contacted the physician to</p>	G 143			

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G 143	<p>Continued From page 25</p> <p>report that the patient was not given her Coumadin since admission to the agency and that the physician requested changes in the Coumadin dosages. The PTA also wrote a case conference note dated 11/28/08, that she spoke to the Supervising Nurse, physical therapist and the RN case manager about the patient's headache, blood pressure and non-compliance with Coumadin. There was no documentation that the PTA informed the skilled nurse about the physician's request for changes in Coumadin dose. The RN case manager again failed develop a coordinated plan to ensure that the patient's now elevated blood pressure and medication compliance was monitored.</p> <p>Despite being informed about the patient's elevated blood pressure and medication non-compliance, the RN case manager failed to recognize the importance of conducting an assessment visit until 3 days later on 12/01/08.</p> <p>On 12/01/08, the RN case manager documented "compliant with medication regimen per daughter" and that there were no medication changes since the last nursing visit on 11/26/08.</p> <p>Evidence is lacking that the skilled nurse ever assessed the dose and frequency with which the patient was taking coumadin and the patient's compliance with Coumadin dose changes documented during the PTA visit on 11/28/08.</p> <p>The skilled nurse failed ensure a coordinated plan was developed to evaluate the patient's continued need for monitoring of blood pressure medication compliance and teaching prior to the RN case manager discharging the patient on 12/04/08.</p>	G 143			

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G 143	<p>Continued From page 26</p> <p>Specifically, the RN case manager visited the patient on 12/04/08 and documented that she instructed the patient to continue taking her medications as ordered. Despite the patient's history of medication non-compliance, the RN case manager failed to document a review of medications with the patient/caregiver, and failed to communicate with the physical therapist or physical therapy assistant to ensure that the patient's on-going blood pressure assessment, medication monitoring and teaching needs were met.</p> <p>Physical therapy visits were continued twice weekly from 12/04/08 to 01/12/09. During these visits, the patient experienced episodes of elevated blood pressure and medication non-compliance as follows:</p> <ul style="list-style-type: none"> <li>- on 12/22/08 the PTA documented a blood pressure of 194/86;</li> <li>- on 12/26/08 the PTA documented a blood pressure of 190/90</li> </ul> <p>During these visits the PTA either failed to document the patient's compliance with blood pressure meds or documented that the patient was non compliant.</p> <p>Although the physical therapist visited the patient on 12/29/08, and assessed the patient's blood pressure was normal, the physical therapist failed to recognize that the patient continued to be non compliant with medications and failed to assess the need for the reinstatement of skilled nursing services for teaching and assessment.</p> <p>o on 01/05/09, the PTA visited the patient and again documented an elevated blood pressure of</p>	G 143			

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G 143	<p>Continued From page 27</p> <p>170/100. The PTA documented that again the patient had not taken her blood pressure medications and failed to report the patient's non-compliance with the physical therapist.</p> <p>The PTA also visited the patient on 1/07/09 and 01/09/09, and documented that the patient's blood pressure was within normal limits, no review of medication compliance or communication with the physical therapist</p> <p>o on 01/12/09, the PTA attempted to visit the patient and told by the patient's caregiver that the patient was seen in the emergency room on 01/11/09 because she started to "pass out". The PTA documented in a case communication note dated 01/12/08, that the emergency room physician told her that patient was being over-medicated for blood pressure.</p> <p>Failure to communicate changes in the patient's blood pressure and medication non-compliance between the PTA and physical therapist and failure of the therapist to assess the patient for continues nursing services, resulted in an incomplete plan to address the patient's medication compliance.</p> <p>This record was reviewed with the acting Administrator and the Supervising Nurses on 02/03/09. An interview with the Director of Physical Therapy was conducted on 03/11/09. No further information was provided regarding the lack of communication.</p> <p>3. Patient # 19 was admitted to the agency on 09/19/08 with a primary diagnosis late effect cerebral vascular accident with cognitive deficits and secondary diagnoses of type II diabetes,</p>	G 143			

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G 143	<p>Continued From page 28</p> <p>hypertension, aphasia and a pressure ulcer of the heel. During the initial nursing assessment, the skilled nurse documented that the patient has expressive aphasia; dysphagia (swallowing difficulties) requiring a gastric feeding tube; tube feeding to be administered by the patient's wife and nothing by mouth (NPO).</p> <p>The lack of case management/coordination by the RN case manager and the lack of communication between the disciplines resulted in:</p> <ul style="list-style-type: none"> <li>- failure to develop a plan to ensure that the patient is safely managed at home</li> <li>- failure to report changes in the patient's status to the physician including changes in diet and medication compliance which may have resulted in aspiration pneumonia.</li> </ul> <p>During skilled nursing visits conducted between 10/15 and 10/23/08, the skilled nurse documented that the patient was eating and drinking. This is against the physician's orders dated 09/18/08 which stated nothing by mouth. The RN case manager failed to communicate the patient's non-compliance to the speech therapist (ST), occupational therapist (OT) and the physician or develop a plan to ensure that all disciplines providing care could assess the patient's safety risk regarding the potential for aspiration associated with eating.</p> <p>The occupational therapist and speech therapist documented during visits conducted on 10/23/08 that the patient had "failed his modified barium swallow" and that the patient continues to eat despite the risks of aspiration. The speech</p>	G 143	<p>Patient #19 The RN case manager has been placed on an action plan and on focused review of her documentation. She has been counseled that if a patient is non-compliant with the POC she must contact the MD. She has been reminded that as a case manager she needs to assess the patient with a wound weekly and anytime the patient's condition changes. She is in the middle of a 4 week plan to improve her documentation. If she does not improve in patient care and documentation, she will be terminated at that time. Pt. discharged</p>	

05-15-09  
Acceptable  
Paul G. Sullivan

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G 143	<p>Continued From page 29</p> <p>therapist documented that she spoke to the speech therapist at the hospital who recommended that as a result of the modified barium swallow test that the patient should remain NPO. Both the ST and OT documented that they discussed the risks of eating and aspiration with the patient and his wife, who informed the therapists that the patient is going to eat and drink if he wants to. The ST and OT failed to communicate the test results or the patient's plan to continue to eat despite the test results and the physician's orders.</p> <p>An LPN visited the patient at 5:30 pm on the same day and failed to assess the patient's oral intake. It is unclear that the LPN was aware of the events of the day regarding the patient's testing results and non-compliance and the risk for aspiration of food and fluid. No subsequent skilled nursing visit was conducted until 10/27/08, 4 days later.</p> <p>On 10/27/08, the RN case manager visited the patient and documented that the patient eats by mouth and has tube feedings 3 times a day. (the plan of care states nothing by mouth and tube feedings 5 times a day). Evidence is lacking that the RN was aware that the patient failed the modified barium swallow and was at continued risk for aspiration as identified by the OT and the ST on 10/23/08. The RN failed to inform the physician of the patient's refusal to follow the plan of care.</p> <p>On 10/29/08, the occupational therapist documented that the patient continues to consume oral intake even with the risks of aspiration, and there was discussion with the RN case manager and or physician consultation.</p>	G 143			



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G 143	<p>Continued From page 30</p> <p>On 10/29/08, the RN visited the patient and again failed to assess the patient's oral intake or the amount, frequency or type of tube feedings administered by the patient's wife.</p> <p>On 10/31/08, the licensed practical nurse (LPN) was scheduled to visit the patient, however, was told by the family that the patient was taken to the hospital for "palpitations". There was no skilled nursing follow-up until 6 days later and no contact with the physician, or the hospital to determine if there was a change in the plan of care.</p> <p>On 11/06/08, a different LPN visited the patient and documented that the patient is "eating full meals, against what the physician wants, per the wife". Although the LPN documented that she reported her visit findings to the RN case manager, no skilled nursing visit was conducted until 5 days later on 11/11/08 and there was no communication with the ST, OT or the physician regarding the patient's non compliance and hospitalization documented on 10/31/08.</p> <p>Between 11/11/08 and 12/03/08, skilled nursing visits were conducted 2 to 3 times a week by LPNs and RNs. The skilled nurses continued to document that the patient was consuming oral intake. There is no evidence of communication between the RN case manager, ST, OT and physician.</p> <p>On 12/03/08, the RN visited the patient and documented a change in the patient's lung sounds. The RN documented that the patient had fine crackles at the lung bases. This change in the patient's condition, a possible symptom of aspiration, was not reported to the physician.</p>	G 143			

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G 143	<p>Continued From page 31</p> <p>On 12/12/08, an LPN visited the patient and documented that the patient had fine crackles. The LPN documented that she reported these abnormal lung sounds to the physician and as a result the physician requested that the patient go to the emergency room for an x-ray to rule out aspiration pneumonia. The patient refused to go due to a lack of transportation. Although, transportation was arranged, the patient refused to go to the emergency room. There is no evidence that the LPN discussed the above findings with the RN case manager and no evidence that the RN case manager developed a plan to ensure that the patient received a chest x-ray to rule out aspiration pneumonia.</p> <p>On 12/16/08, the social worker visited the patient to evaluate the need for transportation assistance and was informed by the patient's wife that the patient was eating and drinking. During the social work visit, the patient's physician called the patient and again stated that the patient needed a chest x-ray. Although the social worker reported this to the RN case manager, evidence is lacking that she develop a plan in collaboration with the physician to ensure that the obtained a chest x-ray.</p> <p>Additionally, although the skilled nurse visited the patient 3 times a week between 12/17/08 to 01/14/09, evidence is lacking that the patient ever had the chest x-ray done to rule out pneumonia or the the RN case manager communicated this to the physician.</p> <p>On 1/14/09 however, an LPN visited the patient and documented that the patient had diminished lung sounds, and was started on an antibiotic on</p>	G 143		

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G 143	<p>Continued From page 32</p> <p>1/12/09. The LPN documented on a case communication note dated 01/14/08 that the patient told her: "this pneumonia is viral related, not aspiration". Evidence is lacking that the RN case manager assessed the patient's condition or consulted with the physician to determine if the antibiotics were started due to aspiration pneumonia.</p> <p>This record was reviewed with the acting Administrator and Supervising Nurses on 02/11/09. No further information was provided.</p> <p>4. Patient # 33 was admitted to the agency on 12/03/08 with diagnoses of dementia, and mental retardation. The lack of case management/coordination by the skilled nurse and a lack of communication between the disciplines has led to the following:</p> <ul style="list-style-type: none"> <li>- lack of specific plan to ensure that the patient's psycho/social needs are met</li> <li>- lack of a plan to ensure that the patient is safe in his home when the caregiver is unavailable</li> </ul> <p>On 12/03/08 the skilled nurse visited the patient and documented that the patient was very forgetful, his mental status was deteriorating, he was dependent on his wife for everything, he had a history of suicide attempts, and his wife was overwhelmed. The 12/03/08 plan of care specified a social work evaluation was to be conducted within 7 days of admission. Evidence is lacking, however, the skilled nurse coordinated with the social worker and identified that the social work evaluation had not been conducted until 12 days after admission on 12/15/08.</p>	G 143	<p>Patient # 33 Patient has been discharged. RN and MSW have been counseled.</p>		

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G 143	<p>Continued From page 33</p> <p>On 12/15/08 the social worker conducted an initial assessment, and identified that the wife was "burned out". Additionally, the social worker documented that the patient was being left alone on Tuesdays and Thursdays when the wife attended classes, and that the wife was questioning the patient's safety during these times. Evidence is lacking that the social worker communicated this to the skilled nurse, and evidence is lacking that the SN or the social worker ever assessed whether the patient was safe being left alone, or coordinated a plan to address the caregiver's stress.</p> <p>Additionally, the social worker documented that she would refer the patient to the Department of Social Services (DSS) Personal Care Aide program for the Tuesdays and Thursdays when the patient was being left alone. Evidence is lacking: that this plan was communicated to the skilled nurse, that the DSS evaluation ever occurred, or that a plan was coordinated to ensure the patient was safe until the DSS evaluation was conducted.</p> <p>On 01/07/08 the skilled nurse documented in the Discharge Summary to the physician that "all possible services were in place". Evidence is lacking however, that the skilled nurse and social worker developed a safe discharge plan for the patient. Specifically, the skilled nurse and social worker failed to identify and report to the physician, that the patient had been discharged from home care services prior to the DSS services being in place, that the patient's safety status was in question, and that the primary caregiver was stressed.</p> <p>Additionally, the "Discharge Summary" which</p>	G 143			

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G 143	Continued From page 34  was sent to the physician indicated the patient was compliant with his diabetes management plan most of the time, which included finger stick blood sugar testing 2 times per day, and insulin injections on a sliding scale 2 times per day. The "Discharge Assessment", however, which was completed on the same day, indicated the patient failed to perform his diabetic regime at least one time per week.  On 02/06/09 the surveyor interviewed the social worker. The social worker stated that it was a "hard call" to determine if the patient was safe at home alone, but that she did not feel that any additional social work visits were needed.  On 02/06/09 the surveyor interviewed the Department of Social Services caseworker, who confirmed that they had not yet assessed the patient.  The patient record was reviewed with the acting Administrator and the Supervising Nurses on 02/09/09. No additional information was provided.	G 143			
G 144	484.14(g) COORDINATION OF PATIENT SERVICES  The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.  This STANDARD is not met as evidenced by: Based on a review of 41 patient records, agency policies and interviews with the acting Administrator and Supervising Nurses, evidence is lacking in 41 records, that case conferences	G 144	See G tag # 143	5/27/09	

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G 144	Continued From page 35 are consistently being conducted as outlined in agency policy and procedures and that there is a mechanism for effectively communicating changes in the patient's condition. Patients # 1-41.  The agency's Coordination of Care/Case Management policy indicates that case conferences will take place: at the time of admission, at least every 60 days throughout the course of care, prior to discharge, and more frequently if necessary.  Lack of adequate coordination of care and case management has the potential for unmet patient needs and possible negative patient outcomes.  During interviews conducted with the acting Administrator and Supervising Nurses on 02/04/09, the Supervising Nurses stated that until 1/16/09, the case conferences were completed in a group setting with all disciplines. The documentation of the case conferences contained in the clinical records for all patients lacked a discussion of the patient's progress towards goals and was more of a report of the patient's current status. The Supervising Nurse stated that as of 01/16/09, the case conferences are being conducted by one on one meetings with the skilled nurse. A review of the documentation of "summary/case conference reports" for January 2009, identified that the documentation remained incomplete and the case conference reports were not signed by the Supervising Nurse who met with the skilled nurse.	G 144			
G 151	484.16 GROUP OF PROFESSIONAL PERSONNEL	G 151			

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NAME OF PROVIDER OR SUPPLIER

**GENTIVA HEALTH SERVICES LIVERPOOL**

STREET ADDRESS, CITY, STATE, ZIP CODE

**200 ELWOOD DAVIS ROAD  
LIVERPOOL, NY 13088**

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G 151	Continued From page 36  This CONDITION is not met as evidenced by: o Failure to participate in an annual evaluation of the agency's program, including a review of the agency's policies and procedures, quality of services provided, and personnel qualifications G153  o Failure to evaluate if agency policy and procedure revision is necessary  o Failure to review the results of agency clinical record audits, develop appropriate action plans to resolve areas in need of improvement, and evaluate the effectiveness and need to revise actions plans G153, 250  o Failure to advise the agency on professional issues. G154  o Failure to evaluate the use of community resources and assist the agency in maintaining liaison with the community G154  The cumulative effect of the agency's lack of a functional Professional Advisory Committee to advise the agency on quality of care issues, resulted in negative outcomes for seven patients: #1, 2, 6, 26, 27, 30, 37 and the potential for negative outcomes for the agency's patient population and the potential for unmet patient needs.	G 151	Revised PI program and PAC to include the following measures: a.) Clinical Record Review results b.) New orientation chart audits c.) Personnel file audits d.) Quarterly policy reviews e.) RN case management case load reports f.) Results of the monthly team audits g.) Adverse events h.) Trends of complaints, incidents and infections i.) Inclusion of the AVP of Regulatory Affairs a member of the governing body is a member of the PAC committee. j.) Pac meetings are held quarterly. The committee will make recommendations on areas requiring improvement that are below expected performance/benchmark. k.) The Governing body will review action plans to determine if they are appropriate to return the deficient area to compliance.  Governing Body weekly calls with the VP of Clinical Operations; the AVP of Regulatory Affairs; the RVP of operations will be held with the Administrator until the conditions are lifted and then become monthly. The members of the calls will be sent Chart audit results; orientation chart audit results and case manager case load reports. These calls will be documented by the governing body.  The Administrator is responsible for all of the above outcomes.	5/19/09
G 152	484.16 GROUP OF PROFESSIONAL PERSONNEL  A group of professional personnel includes at least one physician and one registered nurse (preferably a public health nurse), and	G 152		4/21/09

05-15-09  
Audit not necessary  
acceptable

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G 152	<p>Continued From page 37</p> <p>appropriate representation from other professional disciplines.</p> <p>This STANDARD is not met as evidenced by: Based on a review of the Agency's June 3, 2008 Annual Program Evaluation for 2007 and the minutes of the Professional Advisory Committee (PAC) meetings for 2007 and 2008, and interviews with the agency Administrator and Acting Director of Clinical Management (ADCM) on February 5, 2009, evidence is lacking that the agency's PAC conducts an annual/ongoing review of the services provided by the agency and its two branches.</p> <p>During an interview with the acting Director of Clinical Management on February 5, 2009, who was functioning as the agency Quality Improvement Director up until February 4, 2009, the ADCM stated that the agency supervisors conduct all clinical audits and develop an action plan to address quality issues. She stated that this information is then shared with the Professional Advisory Committee on a quarterly basis.</p> <p>Review of the PAC minutes for meetings on March 3, 2008, June 3, 2008, September 23, 2008, and December 2, 2008, lacks evidence that the committee is reviewing results of the trended data and following a consistent process for the resolution of problem areas. Specifically:</p> <ul style="list-style-type: none"> <li>- The trended data report for the 3rd quarter of 2008 identifies unacceptable percentages in the following areas in Liverpool and its two branches: clinical notes show</li> </ul>	G 152	<p>G 151 484.16 Group of Professional Personnel</p> <p>This includes G tags 152 153, 154.</p> <p>The 2008 annual program evaluation will be completed by members of the governing body the AVP of Regulatory Affairs, the VP of Clinical Operations and the Administrator. The review of this document will be reflected in the minutes of the first quarter 2009 PAC meeting which will be held May 19th.</p> <p>The summary of the quarterly statistics from the chart audits will be presented and an action plan developed to improve areas identified as needing improvement. The improvement will be monitored through comprehensive monthly chart audit results (are the quarterly comprehensive chart audits that are broken down into monthly audits for each quarter so that auditing is continuous) 20% of each team's patient census will be reviewed monthly. The RC 2 will assign the audits the team. The outcome of these audits will be discussed at the multidisciplinary monthly clinical record review meeting. Areas identified needing improvement will have an action plan to improve the documentation. The meetings will have minutes and the minutes will be reviewed at each sequential meeting to ensure the actions have been completed that we assigned the previous month. Each monthly audit score will be combined to provide the quarterly audit score.</p>		5/19/09

*5/15/09  
Acceptable  
Per TC  
Adm. 100  
5/15/09  
Paula  
Williams*



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G 152	<p>Continued From page 38</p> <p>evidence of following the plan of care (68%); complete wound assessment (75%); physician/supervisor notified of changes in patient condition (79%); Home Health Aide notes follow the personal care plan (71%); Home Health Aide is supervised every 14 days (71%).</p> <p>Minutes of the PAC meeting for the 3rd quarter of 2008, dated December 2, 2008 state: "Director of Performance Improvement reviewed and discussed the Quarterly audit report and action plan; Plan of Treatment being followed remains an area of concern for all branches. Plans to correct the areas of improvement reviewed and discussed". However, there is no evidence that each of the areas above were discussed and an appropriate action plan identified.</p> <p>- The trended data report for the 4th quarter identified unacceptable percentages in the following areas for Liverpool and its two branches: clinical notes show evidence of following the plan of care (47%); complete wound assessment (67%); physician/supervisor notified of any changes in patient condition (58%); Home health Aide notes follow the personal care plan (81%); Home Health Aide is supervised every 14 days (80%).</p> <p>The Professional Advisory Meeting minutes were not available at the time of the survey, the performance improvement action plan, failed to identify that there had been a significant decline in: clinical notes showing evidence of following the plan of care; wound assessments; and physician/supervisor notification of changes in patient condition from the third quarter. The action plan also lacked reference to or an</p>	<p>G 152</p> <p><i>5/15/09 accept</i> <i>Anthony Williams</i></p>	<p><i>PAC</i></p> <p>The committee has expanded to have representation from the Therapy Rehab Directors, an OT; a sales team member so they can see how the referral process impacts PI, an open invitation to any field staff who want to attend. We are currently searching for a community representative.</p> <p>The Administrator/DPS is responsible for the chart audit outcomes and improvement. Continued non-compliance will result in disciplinary actions up to and including termination and the documentation of this disciplinary action will be placed in the personnel file.</p>		

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G 152	Continued From page 39 evaluation of the action plan from the previous quarter to determine why the trended data was showing no improvement in the agency's performance..	G 152			
G 153	Failure of the agency to ensure that the Professional Advisory Committee reviews agency policies and procedures and participates in the review of the agency's program, may result in negative outcomes for the patient population. <b>484.16 GROUP OF PROFESSIONAL PERSONNEL</b>	G 153	<i>See Gtag #152</i>		
G 154	The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.  This STANDARD is not met as evidenced by: See G 154  Failure of the agency to ensure that the Professional Advisory Committee reviews agency policies and procedures and participates in the review of the agency's program, may result in negative outcomes for the patient population. <b>484.16(a) ADVISORY AND EVALUATION FUNCTION</b>	G 154			
	The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care				

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G 154	<p>Continued From page 40</p> <p>providers in the community and in the agency's community information program.</p> <p>This STANDARD is not met as evidenced by: Based on a review of the Agency's 2008 Annual Program Evaluation for 2007 and the minutes of the Professional Advisory Committee (PAC) meetings for 2007 and 2008, and interviews with the agency Administrator and Acting Director of Clinical Management on February 5, 2009, evidence is lacking that the agency's PAC conducts an annual/ongoing review of the services provided by the agency and its two branches.</p> <p>Specifically,</p> <ul style="list-style-type: none"> <li>- Minutes of the PAC meetings and the report of the agency's Annual Program Evaluation lack evidence that the PAC committee is reviewing agency policies and procedures. There is no evidence the PAC reviews all of the agency's policies and makes a determination of the effectiveness, appropriateness, and adequacy of those policies. Although the PAC committee completes a corporate form for the annual review, there is no evidence on what basis/information the evaluation is performed. Questions such as "were patient care services appropriate" are checked "yes" and "comments/recommendations:" are typed "none".</li> <li>- Evidence is lacking the PAC advises the agency on ways to maintain liaisons with the community. The Annual Program Evaluation includes a section which states: "Comments regarding service patterns and location responses</li> </ul>	G 154	<p><i>See tag # 152</i></p>		

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G 154	Continued From page 41 to changing community/client care needs". This area is left blank.  - There is no evidence the PAC provides advise to the agency on professional and clinical issues, either in the minutes of PAC meetings or in the body of the Annual Program Evaluation report.  Failure of the agency to ensure that the Professional Advisory Committee reviews agency policies and procedures and participates in the review of the agency's program, may result in negative outcomes for the patient population.	G 154	Revised PI program and quarterly PAC to include the following measures: a.) Clinical Record Review results b.) New orientation chart audits c.) Personnel file audits d.) Quarterly policy reviews e.) RN case management case load reports f.) Results of the monthly team audits g.) Adverse events h.) Trends of complaints, incidents and infections i.) Inclusion of the AVP of Regulatory Affairs a member of the governing body is a member of the PAC committee. j.) PAC meetings are held quarterly. The committee will make recommendations on areas requiring improvement that are below expected performance/benchmark. k.) The Governing body will review action plans to determine if they are appropriate to return the deficient area to compliance.	5/19/09
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  This CONDITION is not met as evidenced by: o Failure to consistently follow a written plan of care. G158  o Failure to implement a system which ensures: that plans of care are comprehensive and address each patient's needs. This survey identifies the agency's failure to develop individualized plans of care which include specific interventions necessary to adequately assess and treat patient conditions and address significant patient symptoms. G159  o Failure to consistently alert the physician when changes in the patient's condition suggest a need to modify the plan of care. G164  The cumulative effect of these systemic problems	G 156 <i>5/15/09 acceptable</i>	100% review by the MCP of all SOC assessments and the POT to ensure accuracy and that the POT is appropriate based on the assessment. This will be documented on the SOC tool.  SOC case conference within the first week of care to review the POC is appropriate to meet the patient's needs	5/27/09

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G 156	Continued From page 42 in the development and implementation of the plan of care resulted in a negative outcomes for seven patients: # 1, 2, 6, 26, 27, 30, 37 and the potential for negative outcomes for the agency's entire patient population and the potential for unmet patient needs.	G 156	As issues are identified field supervision will occur by the MCP/designee with the clinicians. These include but are not limited to: with lack of quality documentation and care issues; patients who have verbalized a compliant with services; New staff within 60 -90 days and existing staff will have their yearly supervisory visits per policy.	5/27/09	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.  This STANDARD is not met as evidenced by: Based on a review of 41 clinical records and interviews with the Supervising Nurses and acting Administrator, evidence is lacking in 18 records that the plan of care developed by the physician is followed by all disciplines providing care. Patients # 1, 2, 5, 6, 9, 10, 16, 17, 19, 23, 29-33, 37, 40, 41.  Failure to to ensure that the plan of care is followed has led to a negative outcome for patient #30 and the potential for negative outcomes for the agency's patient population.  1. Patient # 30 was admitted to the agency on 11/29/08 with a primary diagnosis of non-healing surgical wound and secondary diagnoses of insulin dependent diabetes, hypertension, chronic bronchitis, long term use of anticoagulant and therapeutic drug monitoring. The plan of care stated skilled nursing visits 1 to 3 times a week for 3 weeks then 2 times a month.  The skilled nurse failed to assess the effectiveness of the patient's pain management	G 158	To ensure return to compliance with following the plan of care educational sessions have been provided to the field staff. These include Care coordination and following the plan of care. See tag #140 Through this education and training evidence of the knowledge transfer will be identified through the chart audit process. Clinicians showing trends and patterns with following the plan of care will be placed on focus review by their MCP and will meet with the MCP/designee until audit scores return to benchmark.  The Administrator/DPS will place clinicians with continued non-compliance despite above interventions will be disciplined up to and including termination. This will be documented and placed in the personnel file.	5/15/09 <i>Paula Williams</i>	

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G 158	<p>Continued From page 43</p> <p>regimen and compliance with the 4 pain medications ordered including: Fentanyl patch, Methadone, Lyrica, and a Lidoderm patch.</p> <p>Failure of the skilled nurse to adequately assess pain management as outlined in the plan of care resulted in the patient experiencing uncontrolled pain from 11/29/08 to 01/06/09.</p> <p>Specifically, the skilled nurse visited the patient 7 times between 11/29/08 and 01/06/09 and documented that the patient had a pain intensity of 10 on a scale of 0 to 10. The skilled nurse failed to assess the patient's use of each pain medication and failed to contact the physician to report the patient's uncontrolled pain.</p> <p>Additionally, the skilled nurse failed to follow the plan of care as follows:</p> <p>During the initial nursing assessment the skilled nurse documented that the patient had 6 wounds: two wounds located on the left stump and 4 wounds located on the right lower extremity including the shin, ankle and foot. Evidence is lacking that the skilled nurse provided treatments and assessments as outlined in the plan of care as follows.</p> <ul style="list-style-type: none"> <li>- the skilled nurse visited the patient 6 times between 12/03/08 and 1/06/09. Evidence is lacking that the skilled nurse ever observed/assessed the 4 wounds located on the patient's right lower extremity.</li> <li>- the plan of care included monitoring of the patient's compliance with blood sugar testing and administration of regular insulin coverage 4 times a day. There is no evidence that the skilled nurse</li> </ul>	G 158	<p>The MCP and RN/PT case manager is to be contacted for changes in patient condition. The MCP will ensure that a follow-up visit for assessment has been scheduled by the case manager. The case manager is to contact the MCP with the outcome of that visit. The MCP or patient case manager will contact the MD.</p> <p>The missed visit report which is run weekly by the scheduling staff will identify if RN visits were not completed as it identifies the clinician that missed the visits. The MCP/designee will contact the clinician to determine why the visit was not completed.</p> <ul style="list-style-type: none"> <li>• All MD orders must be followed or if not able to a written note/case communication must be completed to state why the POC was not followed.</li> <li>• The POC must be followed exactly as written</li> <li>• The POC must be holistic and identify all patients' needs</li> <li>• Changes in patient's condition must be assessed by a RN/PT and reported to the MD for any changes in the orders.</li> </ul> <p>This will be monitored through the chart audit process. See G tag #250</p> <p>The Administrator/DPS is responsible for the compliance with MD orders. Continued non-compliance will result in disciplinary actions up to and including termination and the documentation of this disciplinary action will be placed in the personnel file.</p>		

5/15/09 accept table  
Paula J. Williams

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>337255</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/15/2009</b>
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G 158	<p>Continued From page 44</p> <p>assessed the frequency for blood sugar monitoring or that the patient was correctly administering insulin per the sliding scale as outlined in the plan of care.</p> <p>- the plan of care includes measuring of the right lower extremity edema at each visit and reporting changes to the physician. The skilled nurse failed to measure the patient's right lower extremity during skilled nursing visits between 12/03/08 to 01/06/09.</p> <p>This record was reviewed with the acting Administrator and the Supervising Nurses on 02/04/09. No further information was provided.</p> <p>2. Patient # 19 was admitted to the agency on 09/19/08 with a primary diagnosis of late effect cerebrovascular accident and secondary diagnoses of type II diabetes, hypertension and peripheral vascular disease. The plan of care included: skilled nursing visits in decreasing frequency from 3 times a week for 2 weeks to 2 times a week for 2 weeks and once a week for 1 week; physical therapy, speech therapy, and occupational therapy services. The plan of care also included enteral feeding with 5 cans of feeding/day via a percutaneous endoscopic gastrostomy (PEG) and nothing by mouth (NPO); 2 wounds, one wound requiring daily dressing changes performed by the patient's caregiver.</p> <p>Skilled nurse failed to consistently assess the following as outlined in the plan of care:</p> <p>- nutritional status including a consistent assessment of the enteral feeding status and the spouse's ability to administer feedings. Specifically, during skilled nursing visits</p>	G 158	<p><i>See tag # 140 for education and training provided</i></p>		

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G 158	<p>Continued From page 45</p> <p>conducted between 09/19/08 to 10/11/08, the skilled nurse failed to assess and document the type and amount of tube feeding administered by the patient's spouse or if the patient was remaining NPO. The skilled nurse documented that on 10/15/08, the patient was eating solid food. Evidence is lacking that this was reported to the physician or that patient was educated regarding the risks of choking or aspiration.</p> <ul style="list-style-type: none"> <li>- status of the heel wound and the spouse's ability perform wound care to the right heel daily</li> <li>- status of the peg tube insertion site. The skilled nurse failed to assess the condition of the skin surrounding the insertion site and failed to assess if the patient's spouse is consistently providing "peg tube care"</li> <li>- status of medication administration/compliance. Specifically, the plan of care states that patient's medications are to be taken orally, however, the patient is NPO.</li> <li>- compliance with the twice daily blood sugar monitoring and insulin administration</li> </ul> <p>Failure of the skilled nurse to follow the plan of care and provide adequate assessment has placed the patient at risk for aspiration pneumonia. Specifically, on 12/12/08, the skilled nurse documented a change in the patient's lung sounds including crackles throughout his lungs, the physician requested that the patient go to the emergency room. There was no follow-up by the skilled nurse and no evidence of treatment until one month later on 01/14/09 when the skilled nurse documented that the patient was placed on antibiotics. Additionally, evidence is lacking that</p>	G 158		



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G 158	<p>Continued From page 46</p> <p>the skilled nurse ever communicated with the physician.</p> <p>This record was reviewed with the acting Administrator and the Supervising Nurses on 02/09/09. No further information was provided.</p> <p>3. Patient # 29 was admitted to the agency on 11/04/08 with a primary diagnosis of physical therapy and secondary diagnoses of hypertension, osteoarthritis and a history of falls. The plan of care included physical therapy visits 3 times a week for 4 weeks, then 2 times a week for 2 weeks. Evidence is lacking that the physical therapist visited the patient at the frequency specified in the plan and following a fall in which the patient sustained a laceration to the hand and a black eye.</p> <p>Specifically, the physical therapist only visited the patient twice a week between 11/08/08 to 12/03/08 not 3 times a week as outlined in the plan. Additionally, there were no physical therapy visits in the clinical record after the 12/03/08 visit and the plan of care specified that physical therapy visits should continue until 12/16/08, which was 6 weeks.</p> <p>The clinical record did contain a summary/case conference report note dated 12/10/08 written by the physical therapy assistant (PTA). In the case conference note, the PTA documented that she called the patient on 12/05/08 to schedule a visit and was told by the patient that she fell the day before, suffered a laceration to the right hand requiring stitches and a black eye. Evidence is lacking that the physical therapist continued to visit the patient at the frequency stated in the plan of care or assessed the need to update the plan</p>	G 158		

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G 158	Continued From page 47 of care to include a referral to skilled nursing to assess the patient's hand laceration.  During the record review on 01/20/09, the surveyor could find no further documentation since the 12/10/08 case conference document and requested the additional information from the Supervising Nurse.  On 01/21/09, the Supervising Nurse gave the surveyor a document which stated that the patient was discharged from the agency on 12/05/08. The surveyor asked the Supervising Nurse: why the document was not in the clinical record; why documentation of a case conference held on 12/10/08 was in the record; and why the patient was on the active patient roster if discharged on 12/05/08. The Supervising Nurse could not answer.  On 01/22/08, at 2:30 pm, the surveyor interviewed the physical therapist case managing the patient. The physical therapist stated that he did not go back to see the patient and that he could not explain why the clinical record contained a case conference note dated 12/10/08 which states that the physical therapist will revisit the patient.  Additionally, evidence is lacking that the physical therapist developed a safe discharge plan following the patient's fall on 12/4/08.	G 158		
G 159	484.18(a) PLAN OF CARE  The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional	G 159		

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G 159	<p>Continued From page 48</p> <p>requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 41 clinical records, interviews with the Supervising Nurses and acting Administrator, evidence is lacking in 23 records that the plan of care is of sufficient scope to adequately meet the needs of the patient. Patients # 1, 3-6, 8, 9, 10, 12, 14, 15, 21, 23, 24, 25, 27, 28, 30, 32, 38, 39, 40, 41.</p> <p>Failure to ensure that an adequate plan of care is developed to meet the needs of the patient has the potential for negative outcomes for the agency's patient population.</p> <p>Home Visit</p> <p>1. Patient # 1 was admitted to the agency on 11/26/08 with a primary diagnosis of urinary tract infection and secondary diagnoses of C-5 - C-7 quadriplegia and neurogenic bladder and bowel. The patient has a history of emergent care due to symptoms related to autonomic dysreflexia, a life threatening condition associated with a spinal cord injury. The plan of care dated 11/26/08 included skilled nursing visits 1 time a week for 1 week, 3 times week for 3 weeks, 2 times a week for 2 weeks then 1 time a week for 2 weeks.</p> <p>The plan of care failed to include the following which placed the patient at risk for negative outcomes resulting in hospital admissions related to the spinal cord injury:</p>	G 159	<p>Comprehensive OASIS training is provided each month to new and current clinicians needing reinforcement. This training includes identification of patient needs. Issues will be identified using the SOC audit tool. Deficient practices specific to a clinician will result in the RN meeting with the MCP/designee to do the corrections required and that the follow-up is complete</p> <p>The Administrator/DPS is responsible for compliance. Continued non-compliance will result in disciplinary actions up to and including termination and the documentation of this disciplinary action will be placed in the personnel file.</p>	5/27/09	

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G 159	<p>Continued From page 49</p> <ul style="list-style-type: none"> <li>- direction for the skilled nurse to observe and report symptoms of autonomic dysreflexia to the physician. The symptoms are potentially life threatening and include the following: high blood pressure, blurred vision, pounding headache, nasal stuffiness, flushed face, red blotching on chest, sweating above level of injury, goose bumps, cool, clammy skin, nausea, and feeling anxious.</li> <li>- specific interventions regarding the patient's bowel regimen and the person responsible to perform bowel care</li> <li>- specific interventions related to the foley catheter care including emptying the catheter bag, washing around the catheter.</li> <li>- plan to irrigate the foley catheter to keep free of obstruction</li> <li>- plan to meet patient's needs when mother is working outside the home</li> <li>- plan for the application and removal of left knee brace including the person responsible</li> </ul> <p>This record was reviewed with the Supervising Nurses and the acting Administrator on 02/03/09. No further information was provided regarding the plan of care.</p> <p>Home Visit</p> <p>2. Patient # 15 was admitted to the agency on 12/22/08 with diagnoses of Parkinson's disease and constipation. The plan of care dated 12/22/08 included skilled nursing visits twice a week for 2 weeks and once a week for 2 weeks to assess</p>	G 159			

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G 159	<p>Continued From page 50</p> <p>vital signs including respirations, pain, neurological status and medication set-up. Evidence is lacking that an adequate plan of care was developed to meet the needs of the patient as follows:</p> <ul style="list-style-type: none"> <li>- the 12/22/08 initial nursing assessment indicates that the patient had not had a bowel movement in 6 days since 12/16/08 while in the hospital. Although there was a plan to relieve constipation, there is no plan to assess the patient's knowledge deficit regarding symptoms of constipation, including diet and fluid intake.</li> <li>- the skilled nurse documented during the initial nursing assessment that the patient lived alone, and the medications are pre-poured by the skilled nurse. The plan of care failed to address who is responsible for the following intervention: "an enema or suppository if no BM (bowel movement) in 3 days". Additionally, there is no plan for the patient to receive twice daily laxative that is ordered by the capful and can not be pre-poured.</li> <li>- the skilled nurse documented the following personal care deficits in the initial nursing assessment and the plan of care failed to address these needs: <ul style="list-style-type: none"> <li>- someone must assist the patient to don undergarments, slacks, socks and shoes</li> <li>- unable to use the shower or tub and is bathed in bed or bedside chair</li> <li>- transfers and ambulates with an assistive device</li> <li>- unable to prepare light meals</li> <li>- unable to do any laundry and housekeeping due to physical limitations</li> </ul> </li> </ul>	G 159		

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G 159	<p>Continued From page 51</p> <p>On 01/27/09, the surveyor conducted an observational home visit with the occupational therapist at 1 pm. During the visit, the patient informed the surveyor that she was receiving aide service 5 days a week from a Licensed Home Care Services Agency (LHCSA). This record was reviewed with the Supervising Nurse and Administrator on 02/03/09, as of this date, the agency was unaware that the patient was receiving aide service from the Office for the Aging.</p> <p>On 03/05/09, the surveyor contacted the licensed agency that was providing aide service to the patient and interviewed the Director of Patient Services (DPS). The DPS stated that this patient is receiving personal care aide service from the Office of the Aging 5 days a week and has been since 12/16/08 when she was discharged from the hospital. During the interview with the Supervising Nurse on 02/03/08, she stated that she would look into the issue however, no further information was provided.</p> <p>3. Patient # 5 was admitted to the agency on 12/26/08 with a primary diagnosis of acute renal failure and secondary diagnoses of insulin dependent diabetes, hypertension, hypothyroidism, diabetic neuropathy and sleep apnea. The plan of care dated 12/26/08 stated skilled nursing twice a week for 2 weeks, once a week for 1 week then twice a month for 1 month to assess the patient fistula, assess vital signs, assess blood sugar monitoring. Evidence is lacking that the plan of care is of sufficient scope to ensure that the patient's needs are met as follows:</p> <p>- the plan of care failed to include an assessment</p>	G 159			

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G 159	<p>Continued From page 52</p> <p>of the patient's skin and a plan for the application and removal of bilateral leg wraps identified during the initial nursing assessment dated 12/26/08. Specifically, the skilled nurse documented "client states she no longer has ulcers or edema on her legs with the bilateral leg wraps".</p> <ul style="list-style-type: none"> <li>- the skilled nurse documented the following personal care deficits during the initial nursing assessment completed 12/26/08 however, the plan of care failed to address these needs:</li> <li>- totally dependent for grooming</li> <li>- totally dependent for dressing lower body</li> <li>- requires assistance or supervision to use the shower or tub</li> <li>- unable to transfer self but is able to bear weight or pivot</li> <li>- unable to plan and prepare meals, do laundry, or housekeeping</li> </ul> <p>The skilled nurse documented that she reviewed the plan of care with the physician following the initial nursing assessment. The physician ordered home health aide service 3 times a week. There is no evidence that the physician was informed that the patient would not be receiving aide service as discussed during the initial nursing assessment.</p> <p>The above findings were reviewed with the Supervising Nurses and Administrator on 01/26/08. During the review, the surveyor questioned the discrepancy between the initial physician verbal order and the subsequent plan of care which lacks home health aide service. The Supervising Nurse stated that the patient was aware that "insurance doesn't cover home health</p>	G 159			

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G-159	Continued From page 53	G-159		4/22/09 Continue	
G-164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE  Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.  This STANDARD is not met as evidenced by: Based on a review of 41 clinical records, and interviews with the acting Administrator and the Supervising Nurses, evidence was lacking in 22 records that the physician is consulted when changes in the patient's condition occur that may require a change in the plan of care. Patients # 1, 2, 5-8, 14-16, 19, 22, 24-27, 29-33, 36, 40.  Failure to ensure that the physician is notified of changes in the patient condition have resulted in negative outcomes for patient's #1, 6, 26, 30 and the potential for negative outcomes for the agency patient population.  1. Patient #26 was admitted to the agency on 12/10/2004 with diagnoses of Alzheimer's disease and urinary incontinence requiring an indwelling urinary catheter. The plan of care for the certification period 11/19/08 to 01/17/09 stated skilled nursing visits one (1) time a month for 2 months to assess the patient, and change the urinary catheter; home health aide visits 3 times a week for 1 week, then 5 times a week for 7 weeks.  Evidence is lacking the RN case manager recognized changes in the patient's condition that	G-164	The MCP reviews 100% of the SOC Assessment and the POC. In addition case conferences occur at the SOC, resumption of care, recertification, and prior to discharge. Case conferences occur with wound care patients and with changes in the patient's condition. Evidence of these conferences will be present in the medical record.  In order to facilitate care coordination field staffs were assigned to teams. In this team each 2RN staff has an assigned LPN to be a part of the care team providing care to the patient. The PT staff is assigned a PTA in the same model. The RN and PT are responsible to assign visits to the LPN/PTA staff. The LPN/PTA will call and update the case manager with the visits made daily. This will be documented in the medical record. The MCP of the team is responsible to facilitate this model.  The MCP, MD and RN/PT case manager is to be contacted for changes in patient condition. The MCP will ensure that a follow-up visit for assessment has been scheduled. The case manager is to contact the MCP with the outcome of that visit. <i>as evidenced in the documentation</i>	5/11/09 Continue  5/11/09 Continue	



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PRINTED: 05/06/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337255	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/15/2009
NAME OF PROVIDER OR SUPPLIER  GENTIVA HEALTH SERVICES LIVERPOOL			STREET ADDRESS, CITY, STATE, ZIP CODE 200 ELWOOD DAVIS ROAD LIVERPOOL, NY 13088		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 164	<p>Continued From page 54</p> <p>require physician consultation. As a result of the RN's failure to recognize and report changes in condition, the physician was not notified when the patient's condition deteriorated; was transported by ambulance to the hospital and subsequently died.</p> <p>Specifically, the RN case manager visited the patient twice weekly from 11/28/08 to 12/12/08. During these visits the skilled nurse documented the following changes in the patient's condition that were not reported to the physician.</p> <p>On 11/28/08 the skilled nurse documented an elevated heart rate of 100 beats per minute (bpm); the patient's husband was having difficulty feeding the patient and the patient's urine was "more amber than usual".</p> <p>On 12/01/08, the skilled nurse documented that the patient's heart rate was now elevated to 108 bpm and respiratory rate was now slightly increased to 24. The RN case manager again documented that the patient had "darker" amber urine.</p> <p>On 12/01/08, at 7:30 pm the skilled nurse on-call visited the patient at the husband's request stating that the patient would not wake up. The skilled nurse visited the patient and documented that the patient's heart rate remained elevated at 104 bpm, she was less alert than during the 11/14/08 assessment, that the urine output was very low at 150 cc amber urine since 11 am. The skilled nurse documented that she attempted to contact the physician but was unable to reach him. At the bottom of the 12/01/08 skilled nursing visit note, the skilled nurse documented that on 12/02/08 that she called the physician and spoke</p>	G 164	<p>Changes in patient condition are to be reported to: The MD with documentation stating the MD was contacted and any new interventions or changes in the POC written as a verbal order. If a LPN/PTA observes a change in condition they must report this to the RN/PT case manager and the MCP. The MCP is to contact the case manager to ensure the patients' needs are met and that the MD is aware. This is documented on a case communication form. Failure to follow</p> <p>process and reporting a change in condition will result in the disciplinary process for the clinician and the MCP. The DCM/designee is to monitor that this occurs. <i>through</i> Evidence in the chart audits that this review does not occur or has improved will be monitored as part of the audit and reported on monthly.</p> <p>See chart audit process G tag # 250</p> <p>The Administrator has the over-all responsibility to ensure this is compliant.</p>	5/15/09	

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STREET ADDRESS, CITY, STATE, ZIP CODE

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G 164	<p>Continued From page 55</p> <p>to a nurse, however, the skilled nurse failed to document the details of what was discussed with the physician's nurse.</p> <p>On 12/04/08, the skilled nurse documented a blood pressure of 74/64; that the blood pressure was low because of a poor blood pressure cuff fit; that the urine output was 200 cc, and contained flecks of red. Although the skilled nurse documented that she reported the patient's blood pressure, blood in urine and urine output to the physician, there was no documented response from the physician, and no evidence that the skilled nurse recognized the need to reassess the patient's blood pressure with a different blood pressure cuff to ensure accuracy of the blood pressure.</p> <p>An interview with the nurse at physician's office was completed by the surveyor on 02/25/09 at 2:30 pm to determine the extent of the information provided to the physician regarding the patient's condition. The physician's nurse told the surveyor that she looked in the patient's record and in the computerized phone log for a record of calls from the home care nurse. The only documented information was on 12/04/08 was an "FYI" regarding the patient's decreased urine output. The physician's nurse stated that they were not informed about the patient's deteriorating condition.</p> <p>On 12/12/08, at 4:45 pm, the LPN visited the patient and documented that the patient was unresponsive, urine was dark amber, had a temperature of 99.1 and that she was "unable to hear" the patient's blood pressure. There was no evidence that the LPN reported the inability to hear the patient's blood pressure and low grade</p>	G 164		

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G 164	<p>Continued From page 56</p> <p>fever to the RN case manager or the physician.</p> <p>On 12/16/08, the patient was transported to the emergency department by ambulance and died.</p> <p>Although there is a document labeled a "late entry" note dated 12/17/08 which stated the following: "spoke to the nurse at MD office, unable to hear blood pressure at this time VS (vital signs) otherwise stable no change in orders given", the surveyor contacted the physician's office on 02/25/09 at 2:30 pm to verify the information documented by the LPN in the late entry note. The nurse at the physician's office informed the surveyor that they had no record of a call from this agency on 12/12/08 and told the surveyor that "if they (the MD office) had received that information (unable to hear a blood pressure) they would have requested another visit be completed and that they would have documentation of the call".</p> <p>This record was reviewed with the Director of Clinical Management and Administrator 01/14/09 and with the acting Administrator and the acting Director of Clinical Management on 03/16/09. No further information was provided. The Director of Clinical Management stated that the agency reviewed the circumstances surrounding the patient's death and found no significant issues with the nursing care. The Director of Clinical Management did not address the issues regarding assignment of an LPN to provide assessments and the lack of LPN communication with the Supervising Nurse to report the inability to hear a blood pressure. The Director of Clinical Management also stated that the LPN did report the blood pressure issues to the physician and referred to the late entry note dated 12/17/08.</p>	G 164		

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G 164	<p>Continued From page 57</p> <p>2. Patient # 1 was admitted to the agency on 11/26/08 with a primary diagnosis of urinary tract infection and secondary diagnoses of C-5 - C-7 quadriplegia and neurogenic bladder and bowel. Evidence is lacking that the skilled nurse reported changes in the patient's condition which resulted in an emergency room visit for bronchitis and a urinary tract infection.</p> <p>Specifically:</p> <ul style="list-style-type: none"> <li>- On 12/12/08, the LPN documented patient had a temperature of 99.1, and had a blister on the left heel which was not previously noted and was covered with a Band-Aid. There was no call to the physician to report the patient's low grade temperature and new blister.</li> <li>- On 12/20/08 the skilled nurse again documented that the patient was having a low grade temperature, dizziness and nausea and vomiting. According to the patient's mother, the patient was in the emergency room on 12/17/08 and 12/18/08. The skilled nurse failed to contact the physician to discuss any changes in the plan of care as a result of the hospital visits, or to report the low grade temperature, nausea and vomiting and dizziness.</li> </ul> <p>As a result, the hospital records show that the patient was also seen in the emergency room on 12/22/08 which resulted in the patient being placed on antibiotics for symptoms of a urinary tract infection and green sputum caused by bronchitis.</p> <p>The skilled nurse visited the patient on 12/24/08 and documented "patient states on antibiotic not</p>	G 164		

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G 164	<p>Continued From page 58</p> <p>sure what". The skilled nurse then wrote out Vantin 200 mg 2 tabs 2 times a day. The skilled nurse relied on the patient's information, there is no evidence that the skilled nurse reviewed the prescription bottle. The skilled nurse failed to report that the patient had been seen in the emergency room and confirm the medication change or discussed an updated plan of care following the emergency room visit.</p> <p>This record was reviewed with the Supervising Nurses and the acting Administrator on 02/03/09. No further information was provided regarding the plan of care.</p> <p>3. Patient #6 was admitted to the agency on 11/20/08 with a primary diagnosis of after care following a total hip replacement and secondary diagnoses of type II diabetes, ulcer of the heel and midfoot and hypertension. Although the skilled nurse documented that she contacted the physician following the initial nursing assessment on 11/20/08, evidence is lacking that she informed the physician of the following abnormal findings:</p> <ul style="list-style-type: none"> <li>- wheezing throughout his lung fields, a loose cough</li> <li>- can only ambulate 10 feet without becoming fatigued and short of breath with ambulating less than 20 feet.</li> <li>- confusion during the day and night but not constantly</li> <li>- requires assistance to groom, dress upper and lower body, bathe, toilet, and ambulate</li> <li>- patient's wife is overwhelmed with the patient's care</li> </ul> <p>Additionally, evidence is lacking that the skilled</p>	G 164		

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G 164	<p>Continued From page 59</p> <p>nurse reported the following changes in the patient's condition as documented in the 11/26/08, skilled nursing assessment visit.</p> <ul style="list-style-type: none"> <li>- weight 130 pounds - representative of a 6 pound weight loss in 6 days. The nurse failed to assess the patient's appetite, food and/or fluid intake and report to the physician.</li> <li>- abnormal respiratory assessment which included an assessment "rhonchi right and left".</li> <li>- if the care giver continued to be overwhelmed with the patient's care.</li> </ul> <p>The very next morning, on 11/27/08, the patient's condition deteriorated to the point that the patient's wife contacted the on-call nurse who visited the patient and arranged for the patient admission to the hospital.</p> <p>A review of the hospital record documented that the patient was admitted with shortness of breath, wheezes and crackles throughout his lung fields. The patient also reported to the emergency room physician that his symptoms started 2-3 days ago.</p> <p>This record was reviewed with the acting Administrator and Supervising Nurses on 02/03/09. No further information was provided.</p> <p>4. Patient # 30 was admitted to the agency on 11/29/08 with a primary diagnosis of non-healing surgical wound and secondary diagnoses of insulin dependent diabetes, hypertension, chronic bronchitis, long term use of anticoagulant and therapeutic drug monitoring. The plan of care dated 11/29/08, stated skilled nursing visits 1 to 3</p>	G 164		

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G 164	Continued From page 60 times a week for 3 weeks then 2 times a month to assess pain and medication effectiveness, the plan also stated that the physician ordered 4 pain medications: Fentanyl patch, Methadone, Lyrica, and a Lidoderm patch.  The skilled nurse failed to report the patient's ineffective pain management regimen to the physician, resulting in the patient experiencing uncontrolled pain from 11/29/08 to 01/06/09.  Specifically, the skilled nurse visited the patient 7 times between 11/29/08 and 01/06/09 and documented that the patient had a pain intensity of 10 on a scale of 0 to 10.  Evidence is lacking that the skilled nurse assessed the patient's consistent use of pain medication as ordered and failed to report the patient's uncontrolled pain to the physician.  This record was reviewed with the acting Administrator and Supervising Nurses on 02/04/09. No further information was provided.	G 164			
G 168	484.30 SKILLED NURSING SERVICES  This CONDITION is not met as evidenced by: o Failure to ensure that skilled nurses are instructed and adequately trained to perform comprehensive nursing assessments which identify each patient's individual needs. Nursing assessments are incomplete and do not consistently reflect the patient's baseline status. See G171  o Failure to consistently reevaluate the patient's condition. See G172	G 168			

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G 168	Continued From page 61	G 168	<i>See # tag # 140</i>	
	<ul style="list-style-type: none"> <li>o Failure to coordinate care and services. See G143, G144</li> <li>o Failure to ensure that skilled nurses receive adequate training to ensure competency in the skills necessary to implement each patient's plan of care. See G140</li> </ul> <p>The cumulative effect of these systemic issues related to the assessment process resulted in negative outcomes for seven patients: # 1, 2, 6, 26, 27, 30, 37 and the potential for negative outcomes for the agency's patient population.</p>		<p>OASIS training classes are provided monthly; this is training in how to assess the patient and complete an OASIS assessment. From this assessment how to identify patient needs and create a POC. It is provided to new and current clinicians needing to review the OASIS assessment and creating the POT.</p>	<i>monthly</i>
G 171	<p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse makes the initial evaluation visit.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 38 clinical records for patient's admitted to the agency by a registered nurse (Patients # 1-10, 12-27, 30-41), and interviews with the acting Administrator, Supervising Nurses and agency staff, evidence is lacking in 19 records that the initial nursing assessment is of sufficient scope that it identifies the needs of the patient. Patients # 1, 2, 5, 6, 7, 8, 9, 12, 15, 19, 24, 27, 30, 31, 33, 37, 38, 39, 40.</p> <p>Failure to ensure that a complete and accurate initial nursing assessment is developed has led to the failure of the skilled nurse to develop a plan of care to meet the patient's needs has the potential for negative outcomes for the agency patient population.</p>	<p>G 171</p> <p><i>5/15/09 acceptable</i> <i>Paula Williams RN</i></p>	<p>Team audit process: <i>pp</i></p> <p>As part of the quarterly comprehensive record audit each month 20% of that team's census will be reviewed by a MCP/designee. The team's audit scores will be reviewed at the monthly record review meeting and recommendations for improving areas below benchmark will be discussed. The MCP is on the committee and has the accountability that her teams audit scores and documentation is compliant.</p> <p>Peer review process:</p> <p>The MCP/designee on each team will assign 2 charts to be reviewed each quarter by each RN/PT. The outcome of the peer reviews (part of the comprehensive chart audits and integrated into that statistic) will be discussed at the monthly team meetings.</p> <p>Each monthly statistics are compiled into the quarterly statistic presented at the quarterly PAC meetings.</p> <p>The Administrator/DPS is responsible for audits to be completed and documentation shows compliance.</p>	<p><i>5/27/09</i></p> <p><i>5/27/09</i></p>



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G 171	<p>Continued From page 62</p> <p>1. Patient # 1 was admitted to the agency on 11/26/08 with a primary diagnosis of urinary tract infection and secondary diagnoses of C-5 - C-7 quadriplegia and neurogenic bladder and bowel. The initial assessment documented that the patient had a history of emergent care due to symptoms related to autonomic dysreflexia, a life threatening condition associated with a his spinal cord injury, which includes:</p> <p>high blood pressure, blurred visions, pounding headache, nasal stuffiness, flushed face, red blotching on chest, sweating above level of injury, goose bumps, cool, clammy skin, nausea, and feeling anxious</p> <p>The initial nursing assessment failed to include an assessment of:</p> <ul style="list-style-type: none"> <li>- the patient/caregiver's knowledge and treatment of symptoms of autonomic dysreflexia.</li> <li>- how care would be provided when the patient's mother was working.</li> <li>- assessment patient's actual functional limitations. Specifically, the skilled nurse documented that the patient has "upper extremity strength", however, the skilled nurse failed to assess the patient's use of a wheelchair, and the patient's ability to transfer.</li> <li>- the patient's safety related to the ability to leave the home in case of an emergency. The skilled nurse failed to assess if the patient had an emergency plan and if the patient could safely get out of the home in case of a fire.</li> <li>- who is responsible for emptying the urinary</li> </ul>	G 171	<p>The MCP reviews 100% of the SOC Assessment and the POC. In addition case conferences occur at the SOC, resumption of care, recertification, and prior to discharge. Case conferences occur with wound care patients and wit changes in the patient's condition. Evidence of these conferences will be present in the medical record.</p> <p>In addition the review of the assessments and POT by the MCP as part of the supervision of their field staff now will be measured by individual team audit scores. The MCP will be measured by the team's over-all score. They will meet with the DCM/designee monthly to review their audit scores. Those MCP teams where documentation needs improvement the MCP will be responsible to work with their field staff to make sure compliance is obtained. If the audits continue to show non-compliance the clinician and the MCP will be disciplined by the DCM/designee up to and including termination. The audits will be on-going to ensure on-going compliance.</p> <p><i>She will be documented and placed in the personnel file. The Administrator /DPS is</i></p>	<p>05/11/09</p> <p>5/11/09</p>

*Responsible for compliance*

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G 171	<p>Continued From page 63</p> <p>catheter collection bag at least daily.</p> <ul style="list-style-type: none"> <li>- specifics related to the implementation of the bowel program 2-3 times a week by the mother, including the mothers ability and availability to perform.</li> <li>- how the patient's personal care needs would be met. Specifically, the skilled nurse documented that the patient was: <ul style="list-style-type: none"> <li>- totally dependent for grooming</li> <li>- totally dependent for dressing upper and lower body</li> <li>- unable to use the shower or tub</li> <li>- totally dependent for toileting</li> <li>- the patient's ability to transfer was unknown and not assessed</li> <li>- unable to ambulate uses a wheelchair but is able to wheel self independently</li> <li>- unable to plan and prepare meals, do laundry, or housekeeping</li> </ul> </li> </ul> <p>This record was reviewed with the Supervisory Nurse and the Administrator on 02/02/09. No information regarding the above findings was provided.</p> <p>2. Patient # 15 was admitted to the agency on 12/22/08 with diagnoses of Parkinson's disease and constipation. Evidence is lacking that the initial nursing assessment is of sufficient scope to identify the patient's needs as follows:</p> <ul style="list-style-type: none"> <li>- the patient has an admitting diagnosis of constipation and informed the skilled nurse during the assessment visit that she did not have a bowel movement for 6 days after discharge from the hospital on 12/16 to 12/22/08. The skilled</li> </ul>	G 171	<p>The MCP staff will increase their field supervision with their field staff especially those with poor quality of documentation, care coordination and difficult to serve patient, patients/care givers who have voiced a complaint. <i>The current policy states annual supervision</i></p> <p>The Administrator will have conference calls with the MCP bi-weekly and meet in person with the MCP staff the other weeks. This will be to review progress of the plan of correction, audit scores, educational needs, outcome of orientation, case loads and complaints, incidents and any other issues/concerns or needs the MCP staff has.</p> <p>The Administrator has the over-all accountability of the compliance with these standards.</p>		

*acceptable Paula Julliano*  
*5/15/09*

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**200 ELWOOD DAVIS ROAD  
LIVERPOOL, NY 13088**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 171	<p>Continued From page 64</p> <p>nurse failed to assess the patient's usual bowel pattern, the current use of bowel preparations to ensure regular bowel movements, and no evidence of teaching regarding when to notify the nurse and/or physician.</p> <ul style="list-style-type: none"> <li>- the skilled nurse documented that the patient should use an enema or suppository if no bowel movement in 3 days. The plan of care does not include orders for an enema or any type of suppository. Additionally, the skilled nurse failed to assess the patient's ability to self administer the enema or suppository.</li> <li>- the skilled nurse documented that the patient lives alone and has the following deficits in the performance of activities of daily living: <ul style="list-style-type: none"> <li>- someone must put on undergarments, slacks, socks and shoes</li> <li>- unable to use the shower or tub and is bathed in bed or bedside chair</li> <li>- transfers and ambulates with an assistive device</li> <li>- unable to prepare light meals</li> <li>- unable to do any laundry and housekeeping due to physical limitations</li> </ul> </li> </ul> <p>The skilled nurse failed to recognize the need for home health aide assistance and did not develop a plan to meet the patient's personal care needs.</p> <p>The record was reviewed with the acting Administrator on 02/03/09. No further information was provided.</p> <p>3. Patient # 5 was admitted to the agency on 12/26/08 with a primary diagnosis of acute renal failure and secondary diagnoses of insulin</p>	G 171		

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G 171	<p>Continued From page 65</p> <p>dependent diabetes, hypertension, hypothyroidism, diabetic neuropathy and sleep apnea. Evidence is lacking that the initial nursing assessment is of sufficient scope that the patient's current needs are identified and an adequate plan of care is developed to meet those needs as follows:</p> <ul style="list-style-type: none"> <li>- the skilled nurse documented that the patient had decreased mobility and endurance, however, failed to assess the the patient's specific functional deficits.</li> <li>- the skilled nurse failed to observe the patient's lower extremities for skin breakdown and/or edema. Specifically, the skilled nurse documented "client states she no longer has ulcers or edema on her legs with the bilateral leg wraps".</li> <li>- the patient has a left upper arm fistula for hemodialysis, the skilled nurse failed to ensure that the fistula is functional by auscultating a bruit or palpating a thrill.</li> <li>- the skilled nurse documented the following deficits in performing personal care: <ul style="list-style-type: none"> <li>- totally dependent for grooming</li> <li>- totally dependent for dressing lower body</li> <li>- requires assistance or supervision to use the shower or tub</li> <li>- unable to transfer self but is able to bear weight or pivot</li> <li>- unable to plan and prepare meals, do laundry, or housekeeping</li> </ul> </li> </ul> <p>Although the skilled nurse identified the need for a home health aide 3 days a week. Evidence is</p>	G 171		

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G 171	Continued From page 66  lacking that patient ever received home health aide services to meet her needs and there was no indication in the initial nursing assessment why services would not be provided.  The above findings were reviewed with the Supervising Nurses and Administrator on 01/26/08. During the review, the surveyor questioned the discrepancy between the initial assessment and the subsequent plan of care which lacks home health aide service. The Supervising Nurse stated that the patient was aware that "insurance doesn't cover home health aide". There was no assessment of how the patient's needs would be met without home health aide service.	G 171			
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse regularly re-evaluates the patients nursing needs.  This STANDARD is not met as evidenced by: Based on a review of 38 clinical records for patients receiving skilled nursing services (Patients # 1-10, 12-27, 30-41), and interviews with the acting Administrator and Supervising Nurses, evidence is lacking in 20 records that skilled nursing reassessments are of sufficient scope to identify changes in the patient's condition which may require re-evaluation and/or modification in the plan of care. Patients # 1, 2, 5, 6, 8, 9, 10, 15, 16, 19, 20, 21, 22, 23, 26, 27, 30, 31, 32, 41.  Failure to ensure that skilled nursing reassessments are of sufficient scope to identify changes in the patient's condition has led to	G 172	see # tag 171		

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G 172	<p>Continued From page 67</p> <p>negative patient outcomes for patients # 6, 26, 30, 37 and the potential for negative outcomes for the agency patient population.</p> <p>1. Patient #26 was admitted to the agency on 12/10/2004 with diagnoses of Alzheimer's disease and urinary incontinence requiring an indwelling urinary catheter. The plan of care for the certification period 11/19/08 to 01/17/09 stated skilled nursing visits one (1) time a month for 2 months to assess the patient and change the foley catheter, and home health aide visits 3 times a week for 1 week, then 5 times a week for 7 weeks.</p> <p>Evidence is lacking that the skilled nurse recognized changes in the patient's condition, that required immediate medical intervention, and reported these changes to the physician. The patient's condition worsened to the point that 2 days following a skilled nursing visit, the patient was transported to the emergency room and died.</p> <p>The skilled nurse failed to recognize that the elevation in heart rate and darker urine may be related to dehydration and require additional assessment of the patient's mucous membranes and skin turgor.</p> <p>Specifically, on 11/28/08 and 12/01/08, the skilled nurse visited the patient and documented that the patient had an increased heart rate and dark amber urine, there is no evidence that the skilled nurse assessed the patient's fluid intake, skin turgor or mucous membranes of the mouth related to dehydration.</p> <p>On 12/01/08, at 7:30 pm the skilled nurse (who was on-call) received a call from the patient's</p>	G 172			

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G 172	<p>Continued From page 68</p> <p>husband stating that the patient would not wake up. The skilled nurse visited the patient and documented that the patient's heart rate was 104 bpm. and she was responsive only to tactile stimuli by opening her eyes. (During previous visits from 07/02/08 to 11/14/08, the patient was alert but non-verbal). The skilled nurse also documented that the patient's urine output was very low at 150 cc amber urine from 11 am to 7:30 pm. The skilled nurse documented that she attempted to contact the physician but was unable to reach him. At the bottom of the 12/01/08 skilled nursing visit note, the skilled nurse documented that on 12/02/08 she called the physician and spoke to a nurse. The skilled nurse failed to document the details of what was discussed with the physician's nurse.</p> <p>The skilled nurse failed to conduct a visit until 2 days later on 12/04/08 at 9:00 am. During the visit, the skilled nurse documented a blood pressure of 74/64, noted that the blood pressure was low because of a poor blood pressure cuff fit and that the patient's urine output was 200 cc and contained flecks of red. The skilled nurse did not identify the last time the urine collection bag was emptied. The skilled nurse documented that she reported the patient's blood pressure, blood in urine and decreased urine output. There was no response from the physician documented and no evidence that the skilled nurse recognized the need to immediately reassess the patient's blood pressure with a different blood pressure cuff to ensure accuracy of the blood pressure or to send the patient to the hospital for emergent care. The skilled nursing failed to reassess the patient until 4 days later on 12/08.</p> <p>On 12/08/08, the skilled nurse documented the</p>	G 172		

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G 172	<p>Continued From page 69</p> <p>following inconsistent findings: the nurse documented that the patient was unresponsive and that she was being fed by her husband. The skilled nurse failed to assess the patient's intake, skin turgor, mucous membranes or urine output related to determine if the patient had increased symptoms of dehydration and failed to recognize the seriousness of the patient's worsening symptoms. Additionally, the skilled nurse failed to report the patient's decreased responsiveness to the Supervising Nurse or the physician.</p> <p>The skilled nurse failed to recognize the need for an assessment by a registered nurse and assigned a licensed practical nurse (LPN) to reassess the patient. This resulted in the patient never being assessed by an RN again and not being visited by the LPN until 4 days later on 12/12/08.</p> <p>On 12/12/08, at 4:45 pm, the LPN visited the patient and documented that the patient was unresponsive, urine was dark amber, had a temperature of 99.1 and that she was "unable to hear" the patient's blood pressure. There was no evidence that the skilled nurse contacted the physician during the visit and failed to report the patient's condition to the RN case manager or the Supervising Nurse and pursue emergent care for the patient.</p> <p>On 12/16/08, the home health aide documented that patient was transported to the hospital ambulance and died.</p> <p>This record was reviewed with the Director of Clinical Management and Administrator 01/14/09. The Director of Clinical Management stated that the agency reviewed the circumstances</p>	G 172		



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G 172	<p>Continued From page 70</p> <p>surrounding the patient's death and found no significant issues with the nursing care. The Director of Clinical Management also stated that the LPN reported the blood pressure issues to the physician and referred to the late entry note dated 12/17/08. The skilled nurse documented in the late entry note dated 12/17/08: "spoke to the nurse at MD office, unable to hear blood pressure at this time VS otherwise stable no change in orders given".</p> <p>As a follow-up to the clinical record review, the surveyor contacted the physician's office on 02/25/09 at 2:30 pm to verify the information provided by the LPN in the late entry note. The nurse at the physician's office informed the surveyor that they had no record of a call from this agency on 12/12/08 and told the surveyor that "if they (the MD office) had received that information (unable to hear a blood pressure) they would have requested another visit be completed and that they would have documentation of the call".</p> <p>This information was shared with the acting Administrator on 03/16/09. No further information was provided.</p> <p>2. Patient #6 was admitted to the agency on 11/20/08 with a primary diagnosis of after care following a total hip replacement and secondary diagnoses of type II diabetes, ulcer of the heel and midfoot and hypertension. The plan of care dated 11/20/08 to 01/28/09 stated skilled nursing visits twice a week to perform PT/INRs, (a blood test to determine blood clotting time), make coumadin adjustments, check pedal pulses every visit, assess wound care to the left heel that the spouse is to perform daily, monitor glucometer</p>	G 172			

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G 172	<p>Continued From page 71 .</p> <p>readings, that the patient independently records twice a day.</p> <p>Failure to recognize the needs of the patient and provide an adequate skilled nursing assessment resulted in patient hospitalization as follows.</p> <p>During the skilled nursing visit completed on 11/26/08, at 9:25 am the skilled nurse failed to perform an adequate assessment of the patient. Specifically, the skilled nurse documented the following:</p> <ul style="list-style-type: none"> <li>- weight 130 pounds - representative of a 6 pound weight loss in 6 days. The nurse failed to assess the patient's appetite, food and/or fluid intake or signs and symptoms of dehydration such as skin turgor or dry lips.</li> <li>- respiratory assessment included an assessment of breath sounds of rhonchi right and left - the nurse failed to document if the assessment includes all lung fields. The skilled nurse documented that the patient "denies shortness of breath" however, failed to assess the patient's respiratory status on exertion.</li> <li>- assessment the caregivers ability to provide care for the patient following the initial caregiver assessment which states that the caregiver is overwhelmed.</li> </ul> <p>At 06:42 am on 11/27/08, the patient's condition deteriorated to the point that the patient's wife contacted the on-call nurse who made a home visit and documented the following assessment resulting in the patient's hospitalization:</p> <ul style="list-style-type: none"> <li>- elevated heart rate of 112 and a rapid</li> </ul>	G 172			

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G 172	<p>Continued From page 72</p> <p>respiratory rate of 40 with exertion</p> <ul style="list-style-type: none"> <li>- shortness of breath with minimal exertion</li> <li>- thick yellow sputum from a productive cough</li> <li>- that the patient's lips were dry, cracked and his mouth was dry</li> <li>- poor skin turgor, patient not drinking adequately</li> </ul> <p>Based on this assessment the patient was sent to the emergency room. A review of the hospital admission record confirmed that the patient was admitted with shortness of breath and wheezes and crackles throughout his lung fields, and that these symptoms began 2 to 3 days earlier.</p> <p>The patient was discharged from the hospital on 12/19/08 with a new diagnosis of aspiration pneumonia requiring a percutaneous endoscopic gastric (PEG) tube for enteral feeding and blood sugar testing.</p> <p>On 12/20/08, the skilled nurse visited the patient, however failed to provide an adequate assessment of the patient post hospitalization. Specifically:</p> <ul style="list-style-type: none"> <li>- the skilled nurse documented that the patient has a PEG tube there is no assessment of the skin at the insertion site of the PEG tube or the interventions to clean the PEG tube insertion site.</li> <li>- the skilled nurse failed to assess who would perform blood sugar testing. Specifically, the skilled nurse documented that the patient's blood sugar should be tested twice a day, however, the patient could not test his blood sugars and the patient's wife refused.</li> <li>- the skilled nurse documented that the patient's medications are administered by the spouse via</li> </ul>	G 172		

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G 172	<p>Continued From page 73</p> <p>the PEG tube however, there is no evidence of medication review to ensure that all of the patient's medications can be administered through the PEG tube, that the patient's wife was observed administering the medications or flushing the PEG tube.</p> <p>This record was reviewed with the acting Administrator and the Supervising Nurses on 02/03/08. The Supervising Nurses were unaware that the assessment and subsequent plan of care were incomplete.</p> <p>3. Patient #37 was admitted to the agency on 11/06/08 with a primary diagnosis of congestive heart failure and secondary diagnoses of type II diabetes and hypertension. The patient resided in an adult home where she received 24 hour supervision and assistance with medications. The plan of care includes: skilled nursing visits twice a week the first week; 3 times a week for 1 week 2 times a week for 2 weeks then 1 time a week for 5 weeks to assess cardiovascular status every visit, including VS (vital signs) and edema measurements. The plan of care also included a Physical Therapy evaluation.</p> <p>The skilled nurse documented changes in the patient's condition between 11/06/08 and 01/02/09 including reports of chest pain, medication changes, and weight fluctuations related to fluid retention. Despite these significant changes in condition, the skilled nurse made a decision to discharge this medically unstable patient from the agency and the patient expired 8 days later.</p> <p>The following documentation is evidence of the skilled nurse's failure to recognize and assess</p>	G 172			

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G 172	<p>Continued From page 74</p> <p>changes in the patient's condition during skilled nursing visits.</p> <p>On 11/18/08, the skilled nurse documented that the patient had an increase in lower extremity edema and that she left a message at the physician's office to report this. There is no evidence of a response received from the physician's office and a no subsequent skilled nursing visit was planned or completed until 8 days later on 11/26/08.</p> <p>During the skilled nursing assessment visit on 11/26/08, the skilled nurse failed to assess the patient's weight, edema and current medications. The surveyor reviewed the adult home case management notes dated 11/24/08, which stated that the physician had ordered an extra diuretic (Lasix) to be given for 3 days. There is no evidence that the skilled nurse assessed the patient's medication regimen, and identified this change in the patient's medication.</p> <p>The next skilled nursing visit, was conducted on 11/28/08. The skilled nurse noted a weight gain of 9 pounds and significant increases in the leg measurements. Again the skilled nurse documented that she notified the physician of the patient's increased weight however, there was no follow-up by the RN until 5 days later on 12/03/08 and no response from the physician was noted.</p> <p>On 12/03/08, the skilled nurse visited the patient and documented that the patient complained of urinary frequency and left shoulder pain. There is no evidence that this was reported to the physician and no follow-up of the patient's symptoms during the next skilled nursing visit 7 days later on 12/10/08.</p>	G 172		

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G 172	<p>Continued From page 75</p> <p>On 12/10/08, the skilled nurse visited the patient and failed to adequately assess the patient's urinary symptoms which were documented during the 12/03/08 visit. The skilled nurse also failed to review the patient's medications and identify that the patient was started on an antibiotic for symptoms of a urinary tract infection on 12/04/08. This information was documented in a case management note written by Adult Home staff and dated 12/04/08.</p> <p>On 12/10, 12, 17, 21 /08, the skilled nurse visited the patient and documented changes in the patient's condition including increased weights and edema measurements requiring the addition of diuretics.</p> <p>Additionally, during the 12/24/08 the skilled nursing visit, the skilled nurse documented patient complaints of chest pain radiating down the left arm 2 days earlier. There was no subsequent assessment of the patient until 9 days later on 01/02/09.</p> <p>On 01/02/09 the skilled nurse visited the patient and failed to assess the following, which had previously been identified as patient problems:</p> <ul style="list-style-type: none"> <li>- an edema measurement</li> <li>- a weight measurement</li> <li>- symptoms of chest pain</li> <li>- a review of the patient's medications and changes that have occurred prior to discharge.</li> </ul> <p>The skilled nurse discharged the patient without assessing if the patient was stable and failed to discuss the patient's discharge with the physician and or the Adult Home staff. A review of the</p>	G 172			

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G 172	<p>Continued From page 76</p> <p>Adult Home case management notes from 01/05/09 stated that 3 days after discharge the patient was complaining of urinary frequency and by 01/10/09, the patient was complaining of shortness of breath and was admitted to the hospital and died 2 days later on 01/12/09.</p> <p>This record was reviewed with the acting Administrator and Supervising Nurses on 02/09/09. No further information was provided.</p> <p>4. Patient # 30 was admitted to the agency on 11/29/08 with a primary diagnosis of non-healing surgical wound and secondary diagnoses of insulin dependent diabetes, hypertension, chronic bronchitis, long term use of anticoagulant and therapeutic drug monitoring. The plan of care stated skilled nursing visits 1 to 3 times a week for 3 weeks then 2 times a month.</p> <p>The skilled nurse failed to assess the effectiveness of the patient's pain management regimen and compliance with the 4 medications ordered for pain: Fentanyl patch, Methadone, Lyrica, and a Lidoderm patch.</p> <p>Failure of the skilled nurse to adequately assess pain management as outlined in the plan of care resulted in the patient experiencing uncontrolled pain from 11/29/08 to 01/06/09.</p> <p>Specifically, the skilled nurse visited the patient 7 times between 11/29/08 and 01/06/09 and documented that the patient had a pain intensity of 10 on a scale of 0 to 10. The skilled nurse failed to assess the patient's consistent use of each pain medication and failed to contact the physician to report the patient's uncontrolled pain.</p>	G 172		

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G 172	Continued From page 77 Additionally, the skilled nurse failed to assess the following:  - skin integrity. Specifically, during the initial nursing assessment dated 11/29/08, the skilled nurse documented that the patient had 6 wounds: two wounds located on the left stump and 4 wounds located on the right lower extremity including the shin, ankle and foot. During 6 skilled nursing visits completed between 12/03/08 and 1/06/09 there is no assessment of the 4 wounds located on the right lower extremity.  - edema of the right lower extremity. The initial nursing assessment indicates that the patient has a history of right lower extremity edema, during skilled nursing visits completed between 12/03/08 to 01/06/09, there is no assessment of the patients right lower extremity edema.  This record was reviewed with the acting Administrator and the Supervising Nurses on 02/04/09. No further information was provided.	G 172		
G 242	484.52 EVALUATION OF THE AGENCY'S PROGRAM  This CONDITION is not met as evidenced by: The agency failed to implement a program which identifies and resolves problems associated with quality patient care. The 06/03/2008 Annual Program Evaluation for 2007 is not of sufficient scope to identify problem areas in patient care and develop mechanisms for resolutions. Specifically, the Annual Program Evaluation failed to ensure and evaluate the following:  o The appropriateness, effectiveness, and	G 242	The 2008 annual program evaluation will be completed by members of the governing body the AVP of Regulatory Affairs, the VP of Clinical Operations and the Administrator. This will be reflected in the minutes of the first quarter 2009 PAC meeting which will be held May 19th.	5/19/09

5/15/09  
acceptable  
Pawel Wlaniak HHS



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G 242	Continued From page 78 adequacy of agency policies and procedures. G153  o The adequacy of nursing supervision and supervision of paraprofessional staff. G140  o Qualifications and training for skilled nursing staff G140.  o The effectiveness of case management and physician notification/consultation. G143,144  o The accuracy and completeness of patient assessments and reassessments G171  o The agency's ability to develop and implement plans of care which address each patient's needs and assist the patient in reaching established goals G158, 159  o Quality of patient care G250  The cumulative effect of these systemic problems related to the agency's annual evaluation resulted in the home care agency's inability to ensure the provision of quality care and a negative outcome for seven patients: # 1, 2, 6, 26, 27, 30, 37 and the potential for negative outcomes for the agency's entire patient population.	G 242	See gtag 140  See gtag 143, 144  See gtag 158, 159	
G 245	484.52 EVALUATION OF THE AGENCY'S PROGRAM  The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient.	G 245	See gtag 122	

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G 245	<p>Continued From page 79</p> <p>This STANDARD is not met as evidenced by: Based on a review of: the agency's 06/03/08 Annual Program Evaluation for 2007 , Professional Advisory Committee meeting minutes for 2008, and trended data reports from quarterly clinical record reviews for 2007 and 2008, evidence is lacking the Annual Evaluation is of sufficient scope to determine the extent that the agency's services and policies are appropriate, adequate, effective, and efficient.</p> <p>Evidence is lacking the Annual Program Evaluation for 2007 included a review of trended data and identified specific areas in need of improvement. Despite the fact that the agency was cited by the New York State Department of Health at Condition level deficiencies, including a determination of Immediate Jeopardy, during the 1st quarter of 2007; the report, which is documented on a Gentiva corporate form, states services are appropriate, adequate, effective and efficient, and further states under each section "recommendations None". Page 9 of the Annual Evaluation reads as follows: "After a New York State Department of Health Certified Agency survey in the 1st quarter 2007 which found this location out of compliance with 4 Conditions of Participation, referrals were slowed down in order to meet the Plan of correction requirements and staffing needs. We need to slowly and carefully build up trained staff to meet the needs of the patients and the agency". Page 12 states " 1295 + 100% Start of Care and 80% ongoing charts were audited until 7/07". There is no evidence that the results of these audits were reviewed or discussed to identify areas in need of improvement or that a focused action plan was developed to resolve specific problem areas. There is no basis on, or process by, which the</p>	G 245		

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G 245	Continued From page 80 committee made a determination regarding the adequacy, effectiveness, efficiency and appropriateness of agency services and policies.  Failure of the agency's annual evaluation to accurately determine the extent that the program is appropriate, adequate, effective and efficient has resulted in negative outcomes for seven patients: # 1, 2, 6, 26, 27, 30, 37 and has the potential for agency wide unmet patient needs and negative patient outcomes.	G 245	Policy review will be done quarterly as evidenced on the minutes of the quarterly PAC meeting minutes.	
G 248	484.52(a) POLICY AND ADMINISTRATIVE REVIEW  As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient.	G 248	Team audit process: 100% As part of the quarterly comprehensive record audit each month 20% of that team's census will be reviewed by a MCP/designee. The team's audit scores will be reviewed at the monthly record review meeting and recommendations for improving areas below benchmark will be discussed. The MCP is on the committee and has the accountability that her teams audit scores and documentation is compliant.	
G 250	This STANDARD is not met as evidenced by: See G 245 484.52(b) CLINICAL RECORD REVIEW  At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.  This STANDARD is not met as evidenced by: Based on a review of the agency's Quality Improvement Program, Professional Advisory Committee (PAC) meeting minutes, Governing Body meeting minutes and interviews with the	G 250 <i>5/15/09 acceptable</i> <i>Paula J. Wells RN WHS-C</i>	Peer review process: The MCP/designee on each team will assign 2 charts to be reviewed each quarter by each RN/PT. The outcome of the peer reviews (part of the comprehensive chart audits and integrated into that statistic) will be discussed at the monthly team meetings.  Each monthly statistics are compiled into the quarterly statistic presented at the quarterly PAC meetings.  The Administrator/DPS is responsible for audits to be completed and documentation shows compliance.	

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G 250	<p>Continued From page 81</p> <p>Agency acting Administrator and acting Director of Clinical Services (DOCS/DPS), evidence is lacking the agency's Quality Improvement program identified and corrected recurring systemic agency problems. Specifically:</p> <ul style="list-style-type: none"> <li>- There is no evidence clinicians representing all services provided by the agency have been participating in the record review process. An interview on 02/05/09 with the employee functioning as the Quality Improvement Specialist until 02/04/09, confirmed that the monthly record audits were performed by the clinical managers/supervisors. She stated that the agency will begin integrating therapy and social work staff into the process. She also stated the managers develop an action plan and present it to the PAC committee quarterly.</li> <li>- There is no evidence that monthly clinical record audits include both open and closed clinical records. A review of the audit tool and the trending graphs in use during all quarters in 2008 lack evidence of an audit of discharged records.</li> <li>- Evidence is lacking that the audit tool currently in use evaluates quality issues with respect to comprehensive assessment and case management. The tool evaluates the presence or absence of forms.</li> <li>- Evidence is lacking that the agency is developing an action plan to address and resolve identified areas in need of improvement and that the action plan is reviewed and revised quarterly based upon the agency's response. Specifically, quarterly trending reports identify percentages of</li> </ul>	G 250	<p>In addition two Gentiva auditors are here assisting with the audits and working with the MCP and clinical staff on documentation improvements. As part of this review the auditors will provide an educational in-service to the MCP staff in how to audit the clinical record. This will be completed the week of May 18, 2009.</p> <p>The Rehab Directors are reviewing 10% of the therapy charts and working with the therapy staff on their documentation.</p> <p>The Gentiva audit tool is used and entered in UNITY. Reports are run with the trend and outcomes of where we need improvement and drives the action plans.</p> <p>5 orientation charts are being audited by the MCP staff for each one of their new clinical staff. Feedback will then be provided to the clinician and the educator on any trends or patterns discovered.</p> <p>All of the above clinical record audits are a part of the 20% comprehensive quarterly chart reviews, just broken out and used monthly as appropriate to be identifying and correcting documentation issues on an ongoing basis.</p> <p>The RC2 is auditing 10 personnel files per quarter, this will include performance evals and supervisory visits.</p>	<p>5/4/09 to 5/22/09</p>

5/15/09 acceptab  
Paula Williams

(The Gentiva auditors work closely with the MCP staff and clinicians to...)

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G 250	Continued From page 82 completion for quality indicators based on monthly clinical record audits. The 3rd quarter trending report identified 67% compliance in the area of "clinical notes show evidence of following the plan of care", 75% compliance "complete wound assessment". The 4th quarter trending report identified 47% compliance in the area of "clinical notes show evidence of following the plan of care, 67% compliance "complete wound assessment".  There is no evidence the agency's Quality Improvement program: identified the decreased compliance in both areas: reviewed the previous quarter action plan to determine why improvement did not occur; or develop a specific action plan to resolve the problems. Action plans are general and include inservice education and case conferences with supervisors, however there is no mechanism in place to review and revise these plans.  There is no evidence in any of the Professional Advisory meeting minutes for all quarters in 2008 that action plans from the previous quarter are being reviewed and revised based on new trended data.	G 250	Complaints, infections and incidents are discussed at the morning meetings and also trended for PAC quarterly  Dr. Bishop will be reviewing with the PAC meeting a patient who had a potential negative outcome with the PAC committee.  Dr. Bishop will be providing in-services on geriatric care. She is also available to give a physician perspective on difficult to serve patients as needed to the branch.  Through monthly team meetings, medical record committee meetings and the Administrator/DPS meeting with the MCP staff, the focus will remain on compliant documentation. This will be monitored through the above audits listed below. The areas being monitored through PAC are:	5/19/09
G 337	484.55(c) DRUG REGIMEN REVIEW  The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.  This STANDARD is not met as evidenced by: In 13 of 13 observational home visits (100%)	G 337	<ul style="list-style-type: none"> <li>• Chart audit results</li> <li>• Orientation chart audit results</li> <li>• Personnel files and skill checklists</li> </ul>	

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G 337	<p>Continued From page 83</p> <p>conducted by the surveyor with the skilled nurse, and interviews with agency staff, the acting Administrator and Supervising Nurses, evidence is lacking that the skilled nurse is assessing the patient's current medication regime and maintaining an accurate medication list as outlined in the agency's policy manual.</p> <p>Specifically, the agency's policy labeled "3-5 Assessment - Review of patients' medications" states that the patient's medications will be reviewed during the initial assessment and each subsequent assessment. The review will include viewing the bottles and labels of drugs the patient has.</p> <p>Patient # 1, 2, 4, 6, 7, 8, 9, 14, 16, 17, 19, 21, 28, 30, 37.</p> <p>Failure to ensure complete and accurate medication reviews by the skilled nurse has the potential for unmet patient needs and the potential for negative outcomes.</p> <p>Examples are as follows:</p> <p>Home Visit</p> <p>1. Patient # 9 was admitted to the agency on 11/28/08 with a primary diagnosis of end stage renal disease and a history of peripheral vascular disease, status post kidney transplant, an esophageal biopsy, and insertion of a jejunostomy feeding tube. Evidence is lacking that the skilled nurse provided an adequate assessment of the patient's current medications as specified in the agency's policy manual.</p> <p>Specifically, an observational home visit was conducted on 01/23/09 by the surveyor with the</p>	<p>G 337</p> <p>5/15/09</p> <p>Acceptable Paulof William RA</p>	<ul style="list-style-type: none"> <li>• RN case management case loads</li> <li>• Review of the quarterly policy updates and revisions sent out each quarter. This will ensure all policies are reviewed annually</li> <li>• Incidents, complaints and infection trends</li> <li>• Adverse events</li> <li>• 100% SOC/POT reviews to ensure accurate assessments and holistic POT are being completed by the MCP staff</li> </ul> <p>The governing body will participate in PAC with the attendance via conference call or in person of the AVP of Regulatory Affairs.</p> <p>Policy review will be done quarterly as evidenced on the minutes of the quarterly PAC meeting minutes.</p> <p>As part of the initial assessment visit and in subsequent visits the clinician will ask the patient and will review the prescription bottles for any changes in medications. Changes will be incorporated into the medication profile and a case communication sent to the MD.</p> <p>This will be audited as part of the comprehensive chart audit.</p>		

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G 337	<p>Continued From page 84</p> <p>skilled nurse at 3 pm. The skilled nurse conducted a re-certification visit. During the visit, the surveyor observed the skilled nurse rewriting the patient's medication list dated 12/30/08. The skilled nurse failed to look at the patient's medication bottles or review the specific medications the patient was taking with the caregiver as outlined in the agency's policy. During the visit, the surveyor asked the skilled nurse why she was recopying the medication list? The skilled nurse stated that it was the agency's policy to "recopy the medication list with recertification". The skilled nurse was unaware that the agency policy included a review of the medication bottles. As a result, the following medication discrepancies were found during clinical record review:</p> <ul style="list-style-type: none"> <li>- the medication list contained an antidepressant medication, Remeron, however, this medication was not included on the plan of care.</li> <li>- both the medication list and the plan of care stated that the patient's two new medications Lasix (diuretic) and Cipro (antibiotic) were ordered to be taken orally, however, the plan of care dated 11/28/09 documents the patient is not to take anything by mouth.</li> </ul> <p>This record was reviewed with the acting Administrator and the Supervising Nurses on 02/10/09. No additional information was provided.</p> <p>Home Visit</p> <p>2. Patient # 16 was admitted to the agency on 11/06/08 with a primary diagnosis of a non-healing surgical wound, and a history of</p>	G 337		

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G 337	<p>Continued From page 85:</p> <p>insulin dependent diabetes, hypertension and diabetic retinopathy resulting in the patient's limited vision. Evidence is lacking that skilled nurse reviewed medications during visits to ensure that all personnel were aware of the patient's current medication regimen.</p> <p>Specifically, the plan of care stated that the patient requires skilled nursing visits 3 times a week for wound care and ensuring that the patient has prefilled insulin syringes.</p> <p>The RN failed to review the patient's medications during an observational home visit conducted by the surveyor with the skilled nurse at 08:30 am on 01/28/09. At the conclusion of the observational home visit, the surveyor reviewed the medications with the patient and identified the following discrepancies with the medication list which was last updated by the skilled nurse on 01/02/09:</p> <ul style="list-style-type: none"> <li>- the medication list included the following medications that the patient stated that he was no longer taking: Plavix (used to prevent the formation of blood clots) or Percocet for pain.</li> <li>- the medication list failed to include Tylenol Arthritis for pain and hydrocortisone cream to dry itchy skin which the patient stated he was applying.</li> <li>- the medication list states that the patient takes Aleve 200 mg by mouth as needed for pain, the patient stated that he takes this medication twice a day every day not just as needed for pain.</li> </ul> <p>This information was reviewed with the acting Administrator and the Supervising Nurses on</p>	G 337			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>337255</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/15/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GENTIVA HEALTH SERVICES LIVERPOOL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 ELWOOD DAVIS ROAD LIVERPOOL, NY 13088</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	<p>Continued From page 86 02/03/09. No further information was reviewed.</p> <p>Home Visit</p> <p>3. Patient # 21 was admitted to the agency on 01/27/08 with a primary diagnosis of insulin dependent diabetes and a history of diabetic retinopathy, therapeutic drug monitoring, hypertension and long term use of insulin. Evidence is lacking that the skilled nurse is reviewing medications and updating the medication list and plan of care as follows:</p> <p>An observational home visit was conducted by the surveyor on 02/05/09 at 3:30 pm with the skilled nurse. During the visit, the surveyor observed the skilled nurse administering eye drops to both eyes, the surveyor reviewed the medication list which did not include eye drops. Additionally, there was no documentation that the skilled nurse had been administering these eye drops during twice daily visits.</p> <p>This record was reviewed with the acting Administrator and the Supervising Nurses on 02/09/09. No further information was provided.</p>	G 337		

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NAME OF PROVIDER OR SUPPLIER  VNA CENTRAL NEW YORK CHHA			STREET ADDRESS, CITY, STATE, ZIP CODE 1050 W GENESEE STREET SYRACUSE, NY 13204		
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G 000	<p><b>INITIAL COMMENTS</b></p> <p>This Statement of Deficiencies is the result of a survey that was initiated as a complaint investigation # NY00054154, NY00051965, and NY00051555. Deficient practices were identified during the survey resulting in conversion to an Extended survey. During the survey, two additional complaints were received and investigated. # NY0055900 and NY0056561. All five complaints investigated resulted in substantiation of the allegations identified.</p> <p>The survey consisted of: 25 observational home visits and 17 additional record reviews for a total of 42 clinical record reviews. A sample of 7 clinical records including 4 observational home visits were selected for patients enrolled in the Long Term Home Health Care Program. (Patients # 3, 4, 6, 8, 28, 34, 36) Eight clinical records reviewed including 5 observational home visits were selected for patient's receiving Tele-health monitoring. (Patients # 3, 12, 15, 16, 25, 26, 31, 41) Interviews were conducted with the Director of Patient Services(DPS), the Chief Executive Officer (Administrator), the Clinical Managers, and staff members throughout the survey.</p> <p>The following agency records were requested and reviewed during the survey: administrative and clinical policies and procedures; Governing Body meeting minutes dated 02/07 to 2/08; Professional Advisory Committee meeting minutes 02/07 to 02/08; and Continuous Quality Improvement Committee meeting minutes from 01/07 to 12/07.</p> <p>Additionally the following personnel records were reviewed: a sample of 18 personnel records for professional staff and 8 home health aide</p>	G 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Inde L. Shulberg*

TITLE

*President*

(X6) DATE

*6/17/08*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 000	Continued From page 1 records. Personnel A-X	G 000			
G 121	<p>Throughout the survey, each clinical record chosen as part of the sample was reviewed with the DPS and the clinical managers.</p> <p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</p> <p>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>This STANDARD is not met as evidenced by: Based on 6 observational home visits for patients requiring dressing changes (patients # 1, 2, 5, 18, 22, 23); interviews with the Director of Patient Services (DPS), Clinical Managers and reviews of policies and procedures, evidence was lacking during 3 of 6 visits that the agency's skilled nursing staff was able to demonstrate adherence to agency policies and procedures and established infection control practices for dressing changes. Patients # 1, 5, 22.</p> <p>Failure of the Skilled Nurses (SN) to follow infection control practices and agency policies and procedures has the potential for unmet patient needs and possible negative patient outcomes.</p> <p>Examples are as follows:</p> <p>Home Visit</p> <p>1. Patient # 1 was admitted to the agency on 12/25/07 with a primary diagnosis of Peripherally Inserted Central Catheter (PICC) and secondary diagnoses of toe amputation, Insulin dependent</p>	G 121	<p>All Staff will be re educated on infection control practices by June 30, 2008. Education to include Infection Control Policy and Procedures, Standard Precautions, Preparation of Work Area and Bag Technique, and Hand Hygiene.</p> <p>In addition to the above, Nursing staff and Certified Wound Specialists will be educated by June 6, 2008, on Skin and Wound Cleansing, Dressing Changes and PICC Maintenance and Management of Potential Complications.</p> <p>Annual mandatory education and orientation will include the above topic demonstrated in the field and in a laboratory setting as return demonstration as of July 30, 2008.</p> <p>All education above will include input by Clinical Managers, Clinical Nurse Specialist.</p> <p>By: Director of Quality Improvement.</p> <p>See page 6/61 G140 in reference to specific changes in staff supervision.</p> <p>See page 60/61 G250 in reference to ongoing monitoring.</p>	09/30/08	

*6/15/08 Paula Williams RN*  
*acceptable*

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G 121	<p>Continued From page 2</p> <p>diabetes, and chronic renal disease. The plan of care (CMS 485) for the certification period 02/23/08 to 04/22/08 directs the skilled nurse to perform wound care to the left foot amputation site as follows: cleanse with sterile normal saline, apply light layer of Panafil and apply wound vac dressing using black foam to be changed Monday, Wednesday and Friday.</p> <p>On 03/05/08, 1 pm. the surveyor conducted an observational home visit with the skilled nurse (employee F). During the home visit employee F violated agency policy regarding "Infection Control: Standard Precautions" and basic infection control standards of practice as follows:</p> <p>The skilled nurse set up her clean field on the patient's table and began to assemble her supplies. The patient's wound was dressed with Kerlix over the wound vac dressing. The skilled nurse began to remove the soiled Kerlix using the patient's scissors. The skilled nurse placed the patient's scissors onto the carpeted floor between each use while removing the old Kerlix dressing.</p> <p>When the skilled nurse finished removing the old dressing, she placed her scissors that had been on the floor on her clean field. Without changing her gloves, the skilled nurse picked up the sterile saline bottle with the soiled gloves, contaminating the exterior of the normal saline bottle which the patient keeps in the refrigerator with her food.</p> <p>Once the wound was cleansed, the skilled nurse picked up the soiled scissors from the clean field and began to cut the black foam for placement directly into the wound. The skilled nurse failed to clean the scissors that she had placed on the floor while removing the old dressing. Due to</p>	G 121	<p>Patient #1 was discharged May 14, 2008.</p> <p>NB: Patient #1 did not have a PICC but did have a wound vac.</p> <p>Individual employee counseling and education initiated immediately with clinician, including Infection Control Policy and Procedures, Standard Precautions, Preparation of Work Area and Bag Technique, Hand Hygiene, Skin Care, Wound Cleansing and Dressing Change. By: Clinical Nurse Specialist</p> <p>March 13, 2008 clinician performed return demonstration for evaluation and competency was demonstrated in all areas noted above. By: Clinical Nurse Specialist.</p> <p>Additional observation with return demonstration and follow up in home supervision was conducted on March 14, 2008 and June 6, 2008 to ensure clinical competency and consistent adherence to infection control standards. By: Clinical Nurse Specialist</p> <p>Random audits will be completed quarterly per audit schedule. See page 60/61 G250.</p>		

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G 121	<p>Continued From page 3</p> <p>the nature of the infection control issue identified during the visit, the surveyor asked the skilled nurse to stop the procedure until the scissors were cleansed.</p> <p>Immediately following the visit, at 2:30 pm, the surveyor met with the Director of Patient Services to review the issues identified during the home visit. The DPS stated that she will immediately discuss the situation with the nurse and develop an action plan with the nurse.</p> <p>Home Visit</p> <p>2. Patient #5 was admitted to the agency on 02/04/08 with a primary diagnosis of post-operative infection with MRSA following bilateral mastectomies. The physician's order dated 02/20/08 directs the skilled nurse to perform daily wound care as follows: cleanse with sterile saline pack lightly with 1/2 strength Dakins solution soaked 4 x 4's and cover with ABD and secure with Ace Binder.</p> <p>On 02/28/08, the surveyor conducted an observational home visit with the skilled nurse (employee O). During the home visit, the surveyor observed employee O perform wound care. While cleansing the wound with normal saline solution, the solution dripped onto the floor. The skilled nurse wiped up the spilled solution from the floor and discarded the 4 x 4. The skilled nurse then grabbed the normal saline bottle using the same gloved hand and contaminated the exterior of normal saline bottle. The skilled nurse informed the surveyor that the normal saline bottle is kept in the patient's refrigerator.</p> <p>On 04/03/08, at 4:30 pm this record was reviewed</p>	G 121	<p>Patient #5 is currently an active patient.</p> <p>See corrective action pg. 2/61 G121</p> <p>Individual employee counseling and education initiated on April 00, 2008 By: Clinical Nurse Manager</p> <p>Additional observation with return demonstration and follow up in home supervision was conducted on 05/16/08 to ensure clinical competency and consistent adherence to infection control standards. By: QI Coordinator</p> <p>Random field supervision visits will be completed on a quarterly basis per audit schedule. See page 60/61 G250.</p>		

*6/18/08 Paula Williams R/L acceptable*

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G 121	<p>Continued From page 4</p> <p>with the DPS and the clinical managers. No further information regarding this visit was provided.</p> <p>Home Visit</p> <p>3. Patient #22 was admitted to the agency on 01/15/08 with a diagnosis of regional enteritis and peritoneal adhesions requiring total parental nutrition through a Peripherally Inserted Central Catheter (PICC). The plan of care directs the skilled nurse to visit the patient weekly to perform PICC line dressing changes.</p> <p>On 03/07/08, the surveyor conducted an observational home visit with the skilled nurse. The skilled nurse failed to follow agency policies related to cleansing the skin and PICC catheter during dressing changes. Specifically, the skilled nurse cleansed the PICC insertion site with a Betadine swab in an outward motion 3 inches. Then using the same Betadine swab, the skilled nurse cleansed the PICC from the insertion site to the hub of the catheter. The agency policy labeled "Peripherally Inserted Central Catheter Maintenance and Management of Potential Complications" states that the area should be cleansed in a circular fashion from the exit site outward 3 to 4 inches in diameter. There is no provision in the policy for cleansing the catheter from insertion site to the hub. Using the same swab after cleansing the skin from the insertion site outward contaminates the insertion site of the PICC.</p> <p>On 03/11/08, the surveyor met with the DPS and reviewed the issues identified during the home visit. The DPS confirmed that the same swab should not be used to clean the catheter after the</p>	G 121	<p>Patient #22 is currently an active patient..</p> <p>Individual employee counseling and education was conducted on 05/22/08. By: Clinical Nurse Manager</p> <p>Clinician was re educated on and given a copy of policy pertaining to PICC protocol on May 22, 2008. Additional observation with return demonstration and follow up in home supervision will be conducted by June 30, 2008 to ensure clinical competency and consistent adherence to infection control standards. By: Clinical Nurse Manager</p> <p>Random field supervision visits will be completed on a quarterly basis per audit schedule. See page 60/61 G250. See page 2/60 in reference to mandatory education.</p>		

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G 121	Continued From page 5	G 121			
G 140	swab was used to cleanse the rest of the arm. 484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE  Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).  This person, or similarly qualified alternate, participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.  This STANDARD is not met as evidenced by: Based on a review of 42 clinical records and 25 observational home visits, and interviews with the Director of Patient Services (DPS) and Clinical Managers evidence is lacking in 42 out of 42 clinical records (100%), that patient care and services are adequately supervised. Patients # 1-42  o Ensuring that skilled nurses have adequate training and skills to implement accepted standards of practice with respect to infection control and universal precautions and provide specialized nursing care in accordance with agency policies and procedures. See G121  o Ensuring that agency staff identify symptoms which require immediate attention; report these findings to the physician. See G143, G164  o Ensuring that there is a system in place to ensure effective communication and coordination	G 140	Plan for Clinical Department restructuring will be implemented on June 23, 2008 to provide increased supervision and oversight of clinical staff and patient care. The restructuring divides staff into five teams. Each team has a Clinical Manager, Quality Care RN Coordinator, Clerical Support person, and 11 to 19 multi discipline clinical staff members. Four of the teams manage adult patients with a census range of 120-170 patients each. The other team manages pediatric patients with a census range of 100- 200 patients. By: Director of Clinical Operations  Random field supervision visits will be completed on a quarterly basis per audit schedule. See page 60/61 G250.  The Director of Clinical Operations will ensure that case managers receive instruction regarding their responsibilities for appropriate communication with their patients' physicians by June 30, 2008.	10/30/08	

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G 140	Continued From page 6 between all disciplines including tele-health nursing staff and Clinical Managers. G143, G144  o Ensuring that the skilled nurses provide the following essential care components: a complete and accurate initial nursing assessment; development of a comprehensive plan of care that addresses each patient's needs; complete and accurate reassessments. See G159, G164, G171, G172.  Failure to provide adequate supervision has the potential for unmet patient needs and negative outcomes for the agency's patient population.	G 140	To provide oversight of clinicians in the field and ensure effective communication and coordination of care between all resources involved in the patient's care, the Clinical Nurse Manager will ensure each team performs and documents monthly multi discipline caseload review on active patients following the Guidelines for Caseload Review policy. Documentation of caseload review will be completed in each patient's electronic medical record. Implementation of this process will be June 30, 2008.		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES  All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.  This STANDARD is not met as evidenced by: Based on a review of 8 clinical records of patients receiving tele-health monitoring (3, 12, 15, 16, 25, 26, 31, 41), and interviews with the Director of Patient Services (DPS) and Clinical Managers, evidence is lacking in 5 records that significant findings identified during tele-health encounters are communicated to the skilled nurse and/or the physician to ensure that symptoms are assessed and monitored. Patients # 12, 25, 26, 31, 41.  Failure to ensure that care coordination activities occur between the tele-health staff and skilled nursing staff has the potential for negative	G 143	The Coordination of Client Services Policy will be reviewed and updated to include communication standards between telehealth staff and field staff. Staff will be educated on the updated policy by July 31, 2008. By: Director of Clinical Operations  Staff will be educated on viewing patient data collected through telehealth monitoring by July 31, 2008.  Beginning July 31, 2008 a focused audit of 10 percent of telehealth records will be performed quarterly for adherence to the Coordination of Client Services policy and following the POC. Data will be analyzed quarterly for trends and appropriate action plans will be implemented. Results will be reported to CQI and PAC. By: Director of Quality Improvement		



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STREET ADDRESS, CITY, STATE, ZIP CODE  
1050 W GENESEE STREET  
SYRACUSE, NY 13204

VNA CENTRAL NEW YORK CHHA

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G 143	<p>Continued From page 7</p> <p>outcomes for it's patient population.</p> <p>1. Patient # 31 was admitted to the agency on 01/29/08 with a primary diagnosis of pneumonia and secondary diagnoses of chronic kidney disease, esophageal reflux and obstructive sleep apnea. The plan of care includes weekly skilled nursing visits and daily tele-health transmissions. The tele-health nurse failed to communicate changes in the patient's condition with the skilled nurse.</p> <p>Specifically, on 03/02/08 at 3:47 pm the patient transmitted vital signs to the tele-health nurse. The patient's blood pressure was 80/48. At 4:23 pm, the on-call nurse called the patient and documented that the patient complained of chest pressure and visual disturbances. The on-call nurse advised the patient to go to the emergency room for an evaluation. There is no evidence that the skilled nurse was informed that the patient was sent to the hospital.</p> <p>On 03/04/08, the surveyor attempted to conduct an observational home visit with the skilled nurse. The skilled nurse and the surveyor arrived at the patient's apartment, knocked on the door and there was no answer. The skilled nurse did not know where the patient was until she and the surveyor were greeted by the patient's neighbor who proceeded to tell the skilled nurse and the surveyor that the patient was taken to the hospital on 03/02/08. The skilled nurse was unaware that the patient was admitted to the hospital over the weekend. The surveyor contacted the DPS who stated that she was also unaware that the patient had been admitted to the hospital on 03/02/08.</p> <p>The patient was discharged from the hospital on</p>	G 143	<p>Patient #31 was discharged April 24, 2008.</p> <p>The Clinical Nurse Manager educated staff at April Multi Disciplinary Care Team meetings on agency standards for reviewing previous visit documentation and interdisciplinary care plan prior to making home visits using verbal and written instruction.</p> <p>The Clinical Nurse Manager counseled the clinician regarding reviewing previous documentation prior to home visit on May 22, 2008.</p>	

*06/18/08 Paul J. Williams*  
*acceptable*

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G 143	<p>Continued From page 8 03/07/08 with a diagnosis of dehydration.</p> <p>Home Visit</p> <p>2. Patient #25 was admitted to the agency on 11/26/07 with a primary diagnosis of cellulitis of the arm and secondary diagnoses of type II diabetes, congestive heart failure, and hypertension. The plan of care included daily tele-health monitoring of the patient's vital signs, weight, and oxygen saturation.</p> <p>- On 02/20/08, at 08:30 am, the patient's tele-health transmission included a weight of 295.5 pounds, the previous weight noted on 02/19/08 was 298.5 pounds. The tele-health nurse documented that she telephoned the patient. During the telephone contact, the tele-health nurse documented the patient was nauseous and had a decreased appetite. There was no evidence that the tele-health nurse inquired about the patient's ability to take her anti-hyperglycemic medications including insulin. The tele-health nurse left a voice message for the skilled nurse to inform her of the patient's status, the skilled nurse failed to conduct an assessment visit or inform the physician of the patient's nausea.</p> <p>- On 02/21/08, at 08:30 am, the patient's tele-health transmission included a weight of 290.0 pounds. This is an 8.5 pound weight loss since 02/19/08. The tele-health nurse documented that she attempted to contact the patient at 12 noon, however, there was no answer. The tele-health nurse documented that she informed the skilled nurse of the patient's rapid weight loss and that the skilled nurse will</p>	G 143	<p>The Clinical Nurse Manager educated/counseled the Case Manager in May of 2008 regarding communication, Plan of Care, documentation regarding weight loss, failure to make a visit and for not making appropriate contact with the physician.</p> <p>The Case Manager obtains parameters from the physician and communicates parameters and other pertinent information to telehealth nurse for all patient's that have diagnoses that may result in weight loss and/or gain and are participating in the telehome care program. Parameters for significant and severe weight loss/gain have been added to the agency's Policy for Weight Assessment.</p> <p>All staff will be educated on the Policy for Weight Assessment by June 30, 2008.</p> <p>By: Clinical Nurse Specialist</p>		

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NAME OF PROVIDER OR SUPPLIER  VNA CENTRAL NEW YORK CHHA			STREET ADDRESS, CITY, STATE, ZIP CODE 1050 W GENESEE STREET SYRACUSE, NY 13204		
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G 143	<p>Continued From page 9</p> <p>see the patient tomorrow (2/22/08). The physician was not consulted regarding this significant weight loss or nausea.</p> <p>- On 02/21/08, at 7 pm, the patient's daughter called the agency's on-call system and informed the on-call nurse that her mother had not taken her medications or eaten since 02/20/08, has continued to have nausea, vomiting and diarrhea. The patient had taken her Lantus insulin at 10 pm on 02/20/08. The on-call nurse contacted the physician who directed the patient to go to the emergency room. The patient was admitted to the hospital from 02/21/08 to 02/26/08.</p> <p>Although the skilled nurse was informed of the patient's nausea and rapid weight loss, she failed to conduct an assessment visit.</p> <p>This record was reviewed with the DPS and Clinical Managers on 04/03/08. No further information was provided.</p> <p>3. Patient # 41 was admitted to the agency on 03/05/08 with a primary diagnosis of atrial fibrillation and secondary diagnoses of congestive heart failure and hypertension. During the initial nursing assessment, the skilled nurse identified that the patient had a stage II pressure ulcer on her buttocks. There is no evidence of coordination of care between the tele-health nurse, the skilled nurse and the physician as follows:</p> <p>Specifically, on 03/06/08, at 3:40 pm, the patient's tele-health monitor was installed and the patient transmitted a blood pressure of 87/57. The plan of care directed the agency to notify the physician if the patient's systolic blood pressure fell below</p>	G 143	<p>Patient #41 discharged March 13, 2008.</p> <p>See corrective action on pg. 7/61.</p> <p>The Telehealth Nurse was counseled by the Director of Clinical Operations in May of 2008 regarding the need to review the IDT Care Plan for all patients and communicating appropriately with the physician and all disciplines involved in the patient's care.</p>		

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G 143	<p>Continued From page 10</p> <p>88 and diastolic blood pressure fell below 40. There is no evidence that the tele-health nurse identified that this blood pressure was below the reportable parameters. Additionally, the physician ordered a visit by the skilled nurse to manually obtain a blood pressure when the tele-health blood pressure transmitted was below the established parameters. No skilled nursing visit was conducted. There is no evidence that the skilled nurse or the physician was notified of this low blood pressure transmission.</p> <p>During an interview with the surveyor on 04/21/08 at 3:30 pm, the Tele-health Coordinator stated that the tele-health department was not aware of an order to have the nurse perform a manual blood pressure for "blood pressure problems".</p> <p>- On 03/07/08, at 1:07 pm, a tele-health blood pressure of 84/52 was documented. The tele-health nurse failed to report the low blood pressure to the physician and the skilled nurse failed to conduct a visit to manually assess the patient's blood pressure.</p> <p>At 5:54 pm, the tele-health nurse documented calling the patient's daughter regarding the patient's low blood pressure. The tele-health nurse asked the patient to re-test her blood pressure. The patient's blood pressure remained low but was within the parameters at 88/51.</p> <p>- On 03/13/08, at 10:00 am the physical therapist conducted a home visit and documented that the patient's blood pressure was low. The physical therapist documented three blood pressure readings: B/P #1 taken on the right arm while sitting was 81/55; B/P #2 taken on the right arm also sitting was 77/52; B/P #3 taken on the right</p>	G 143	<p>The Physical Therapist was counseled by the Rehab Manager June 6, 2008. At this time an addendum was made to the patient's medical record, documenting the Physical Therapist's phone call to the physician regarding the patient's low blood pressure that was made, but not previously documented.</p>		

*accept 6/10/08  
Pm*

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G 143

Continued From page 11  
arm standing was 78/52. The physical therapist contacted the physician to report the low blood pressure readings. There is no evidence that the physical therapist contacted the skilled nurse or the tele-health nurse to report these significantly low blood pressures.

At 10:30 am, on 03/13/08, the patient's tele-health blood pressure of 81/51 was documented. The tele-health nurse did not contact the patient's daughter over an hour later at 11:53 am. The patient's daughter informed the tele-health nurse that the patient had a low grade temperature and was coughing up brown sputum. The tele-health nurse recommended that the patient be seen in prompt care. The daughter stated that she could not get the patient out of the house to go to prompt care.

There is no evidence that the tele-health nurse spoke to the skilled nurse until 2 pm and informed her about what's going on with the patient. The skilled nurse informed the tele-health nurse that "the nurse" would visit the patient "tonight." At 5:00 pm 6.5 hours after the tele-health blood pressure was documented, the licensed practical nurse visited the patient and obtained vital signs.

On 03/14/08, there was no documentation of vital signs transmitted via tele-health and no evidence that the tele-health nurse communicated with the skilled nurse to report that the patient did not transmit any vital signs.

- On 03/15/08, at 10:30 am the patient transmitted a blood pressure of 113/52. At 11:00 am, the tele-health nurse documented that she called the patient's home and left a message regarding the patient's status and questioning if

G 143

The Telehealth Review and Response to Clinical Data policies will be reviewed and updated by July 31, 2008. The Coordination of Care policy will be revised to include Telehealth, see page 7/61 G143.

By: Director of Clinical Operations

*acceptable 7/10/08*

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G 143	<p>Continued From page 12</p> <p>the patient was taken to "prompt care yesterday". There is no documentation in the clinical record of follow-up communication between the patient's daughter, the tele-health nurse and/or the skilled nurse to determine what happened to the patient on 03/13/08 or why the patient failed to transmit blood pressure readings on 03/14/08.</p> <p>The last documented tele-health transmission in the clinical record was noted on 03/16/08 when the patient's blood pressure was documented as normal. There was no tele-health transmission on 03/17 or 03/18. There was no evidence that the tele-health nurse followed up with the patient or notified the skilled nurse. The only documentation of communication in the clinical record was when the skilled nurse called the patient to schedule a visit. The patient's daughter informed the skilled nurse that another home care agency was providing care.</p> <p>This clinical record was reviewed with the DPS, Administrator and the Tele-health Coordinator on 04/21/08. No further information was provided. The patient was discharged from the agency and is receiving home care services from another certified home care agency.</p> <p>4. Patient #26 was admitted to the agency on 10/08/07 with a primary diagnosis of anemia and secondary diagnoses of congestive heart failure and hypertension. Evidence is lacking that there is effective communication between the tele-health nurse, skilled nurse and the physician. The plan of care included daily tele-health monitoring of the patient's vital signs and weight. There is no evidence that the patient's weight loss documented during tele-health transmissions was identified by the tele-health nurse, discussed with</p>	G 143	<p>Patient #26 was discharged November 26, 2007.</p> <p>See corrective action pg. 7/61 G143.</p> <p>The Telehealth Nurse was counseled by the Director of Clinical Operations. See page 10/61 regarding Telehealth Nurse counseling.</p>		

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G 143	<p>Continued From page 13</p> <p>skilled nurse and the physician consulted.</p> <p>- Specifically, between 10/09/07 and 11/16/07, the patient suffered a 24 pound weight loss.</p> <p>Although the tele-health nurse documented on 11/16/07 that she left a voice message for the skilled nurse, there is no evidence that the skilled nurse visited the patient or consulted the physician regarding this significant weight loss in 1 month.</p> <p>- On 11/26/07, tele-health nurse documented a phone call to the patient's daughter who stated that the patient was admitted to the hospital with a diagnosis of anemia.</p> <p>This record was reviewed with the DPS on 02/22/08. No further information was provided.</p> <p>5. Patient #12 was admitted to the agency on 01/29/08 with a primary diagnosis of pulmonary embolus, hypertension and malignant neoplasm of the large bowel. The plan of care includes weekly skilled nursing visits and daily tele-health transmissions with parameters to report a weight loss of 3 pounds in 1 week. The skilled nurse failed to provide adequate care coordination with the tele-health nurse.</p> <p>- On 03/12/08 at 8:23 pm the on-call nurse received a phone call from the patient stating that she had nausea and vomiting and was concerned about the effectiveness of her coumadin that she had taken at 7:30 pm.</p> <p>- On 03/13/08 at 12:00 midnight, the on-call nurse documented that the patient stated she still had nausea and vomiting and will take Zofran.</p>	G 143	<p>Patient #12 was discharged on May 23, 2008.</p> <p>The Telehealth Nurse and the Case Manager were counseled in May of 2008 regarding agency protocol on communication, review of clinical documentation, care coordination and reporting appropriately to the physician.</p> <p>By: Clinical Nurse Manager</p>	

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G 143	<p>Continued From page 14</p> <p>The on-call nurse documented that she notified the skilled nurse (case manager).</p> <p>- On 03/13/08 at 10:00 am the patient transmitted a weight which reflected 4 pound weight loss in 3 days. As a result of this weight loss, the tele-health nurse contacted the patient and determined that the patient vomited 3 times last night, took "something to settle her stomach" and feels better. The tele-health nurse left a voice mail message for the skilled nurse. Although the skilled nurse documented a phone call to the patient at 3 pm, there was no contact with the physician to report the patient's weight loss and persistent vomiting.</p> <p>There was no transmission of vital signs on 03/15 and 03/16/08 or follow-up communication with the patient to ensure that the patient was safe. There was also no documentation that the tele-health nurse informed the skilled nurse that the patient failed to transmit vital signs.</p> <p>On 03/17/08, at 08:00, the patient transmitted vital signs. The tele-health nurse contacted the patient who explained that she started vomiting again on Friday 03/13/08 and was admitted to the hospital, there was no skilled nursing visit until 03/18/08.</p> <p>There is no evidence that the physician was notified of the patient's continued nausea and vomiting.</p> <p>This record was reviewed with the DPS and Clinical Managers on 04/02/08. No further information was provided.</p>	G 143			
G 144	484.14(g) COORDINATION OF PATIENT SERVICES	G 144		09/30/08	



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G 144	<p>Continued From page 15</p> <p>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 42 clinical records, 25 observational home visits and interviews with the Director of Patient Services (DPS) and Clinical Managers, evidence is lacking in 42 records that case conferences between Clinical Managers and skilled nurses demonstrates that significant patient information regarding the patient's status is discussed. Patients # 1-42.</p> <p>Specifically, the clinical record failed to include documentation that case conferencing between the Clinical Manager and the skilled nurse was occurring. On 03/03/08, the surveyor asked the DPS to explain the process for case conferencing and communication between the Clinical Managers and the skilled nurse. The DPS stated that the documentation of case conferences was not contained in the clinical record, but was kept in a separate binder by each Clinical Manager. The DPS stated that at least monthly, the Clinical Manager met with the skilled nurse and discussed the current cases.</p> <p>A review of the documentation contained in the binder for 2 of the Clinical Managers was completed. There was no evidence that significant patient issues identified in this survey report were discussed with the skilled nurses. The surveyor asked the DPS what was discussed during the case reviews. The DPS gave the</p>	G 144	<p>See page 6/61 G140 in reference to Oversight by Clinical Management.</p> <p>Guidelines for reporting client issues that require Clinical Managers intervention will be reviewed with clinicians at the multi discipline care team meetings by June 30, 2008. Individual case managers will be responsible for reviewing and reporting to Clinical Nurse Manager using the established guidelines.</p> <p>A standardized process for documentation of oversight will be created and implemented by the Clinical Managers by July 31, 2008.</p> <p>By: Director of Clinical Operations</p>	06/30/08	

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G 144	Continued From page 16 surveyor a copy of the policy titled: "Coordination of Client Service" approved on 08/06/05. This policy is vague and does not include specific information to be discussed during monthly case conferences. This was discussed with the DPS on 03/03/08, the DPS then provided the surveyor with a document labeled "Guidelines for Caseload Review". This document contains very specific areas to be discussed during the case conferences with the Clinical Manager and the skilled nurse. There is no evidence that the Clinical Manager used the guidelines during case conferences with the skilled nurse.  Failure to ensure coordination of care and case conferences between the clinical managers and the skilled nurse has the potential for unmet patient needs and the potential for outcomes for its patient population.	G 144			
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence.  This STANDARD is not met as evidenced by: Based on a review of 42 clinical records and 25 observational home visits and interviews with the Director of Patient Services (DPS) and the Clinical Managers evidence is lacking in 5 of 5 clinical records that the patient's accepted for care requiring home health aide services can be met. Patients # 20, 26, 29, 40, 41.  Specifically, for 5 of 5 patients admitted to the	G 157	The Director of Clinical Operations will ensure that patients admitted to the agency meet criteria set in agency policy for admission and that there is a reasonable expectation that their needs can be safely met.  Staff will be educated on Acceptance of Clients and Continuation of Service policy by July 31, 2008.  Clients determined to be eligible for aide service at start of care will be informed up front that aide service in outlying areas may not start immediately. The patient will be given a choice at this time to be referred to another agency for all services and the physician will be informed.		07/01/08

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G 157	<p>Continued From page 17</p> <p>agency with identified personal care needs, the agency failed to ensure that home health aide service was provided.</p> <p>Failure to provide home health aide services has led to unmet patient needs and the potential for negative outcomes for the agency patient population.</p> <p>1. Patient # 26 was admitted to the agency on 10/08/07 with diagnoses of chronic obstructive pulmonary disease and congestive heart failure. The initial OASIS assessment states that the patient requires the presence of another person throughout the bath for assistance or supervision and lives alone. The plan of care developed in collaboration with the physician included home health aide service 2 hours a day 3 days a week for assistance with a shower, shampoo, meal preparation, laundry and light housekeeping. Evidence is lacking that the agency ever provided home health aide service.</p> <p>On 10/17/07, skilled nurse visited the patient. During the visit, the patient asked the skilled nurse when her home health aide service was starting. The skilled nurse stated that the agency was having trouble finding an aide in her area.</p> <p>From 10/09/07 to 11/23/07, the patient was transmitting daily tele-health weight measurements. A review of the tele-health documentation of the patient's daily weight showed a weight loss of 23.5 pounds from 10/09/07 to 11/16/07. There is no evidence that the skilled nurse or the tele-health nurse consistently evaluated the patient's ability to prepare meals.</p>	G 157	<p>The Home Health Aide Service Tracking System policy will be reviewed and revised by July 15, 2008. Revisions will include policy and procedure to ensure timely follow up of unmet HHA services and guidelines for proper communication with client, family and physician.</p> <p>The Home Health Aide Service Tracking System policy will be reviewed will staff by July 31, 2008. By: Director of Clinical Operations</p> <p><i>acceptable</i> <i>not</i> <i>6/18/08</i></p>		

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G 157	<p>Continued From page 18</p> <p>The agency never provided this patient a home health aide. On 11/26/07, the patient was transferred to the hospital.</p> <p>An interview with the DPS was conducted on 02/22/08, regarding the agency's inability to provide a home health aide. The DPS stated that the agency just does not have aides in the patient's geographic area.</p> <p>A note in the clinical record dated 11/29/07 stated that the patient did not want VNA to provide service upon discharge from the hospital. The surveyor asked the DPS why the patient no longer wanted VNA services. She stated that it was because there was no aide service available.</p> <p>2. Patient # 29 was admitted to the agency on 12/03/07 with a primary diagnosis of chronic pain due to trauma and secondary diagnoses of abnormality of gait, reflex sympathetic dystrophy and asthma. During the initial nursing assessment, the skilled nurse documented that the patient was in severe pain and required the assistance of a home health aide 3 times a week. The plan of care developed and approved by the physician included a home health aide 3 times a week, 2 hours a day for assistance with activities of daily living, assistance with transferring, ambulation, meal preparation and personal care.</p> <p>There is no evidence that the agency provided a home health aide to assist the patient with personal care. During weekly skilled nursing assessment visits, the skilled nurse documented that the patient was having pain. There is no assessment of the patient's ability to perform personal care including a bath.</p>	G 157	<p>Patient #29 was discharged December 31, 2007.</p> <p>See page 18/61 G157</p>		

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G 157	<p>Continued From page 19</p> <p>On 01/08/08, the clinical record contained a transfer OASIS assessment indicating that the patient was admitted to the hospital for uncontrollable pain.</p> <p>On 02/22/08, the surveyor met with the DPS to review the findings of the clinical record review. No further information was provided.</p> <p>3. Patient # 41 was admitted to the agency on 03/05/08 with a primary diagnosis of atrial fibrillation and secondary diagnoses of congestive heart failure and hypertension. The clinical record contained a referral to the agency requesting an evaluation for skilled nursing, physical therapy and home health aide services. The referral also indicates that the patient lives with a daughter however, the daughter is planning to return to work therefore, the patient will need a home health aide for assistance.</p> <p>During the initial nursing assessment, the skilled nurse documented that the patient had dyspnea with exertion, decreased muscle strength in bilateral lower extremities, and limited range of motion in bilateral lower extremities. The patient was totally dependent for all activities of daily living including personal care.</p> <p>The agency failed to provide a home health aide to this patient from admission on 03/05/08 to 03/18/08 when the patient was discharged to another certified home care agency.</p> <p>This record was reviewed with the DPS and Clinical Manager on 04/21/08. The DPS stated that although they did not provide a home health aide for the patient, they sent a licensed practical nurse (LPN) to provide personal care for the</p>	G 157	<p>NB: Transfer OASIS incorrect - Addendum was made to OASIS to reflect a planned admission to the hospital.</p> <p><i>After identified by surveyor</i></p> <p>See corrective action pg. 18/61 G157</p>		

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NAME OF PROVIDER OR SUPPLIER  VNA CENTRAL NEW YORK CHHA			STREET ADDRESS, CITY, STATE, ZIP CODE 1050 W GENESEE STREET SYRACUSE, NY 13204		
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G 157	<p>Continued From page 20</p> <p>patient on 03/11/08 and 03/13/08. However, there was no evidence that personal care was provided by the LPN.</p> <p>4. Patient #40 was admitted to the agency on 11/30/07 with a primary diagnosis of malnutrition requiring total parental nutrition (TPN) via a peripherally inserted central catheter (PICC) and secondary diagnoses of anorexia, dehydration and dysphagia. During the initial nursing assessment, the skilled nurse documented that the patient lived alone and required the assistance of a home health aide for personal care. The physician's plan of care dated 11/30/07 includes home health aide services 2 hours a day, 2 days a week for personal care and bathing assistance.</p> <p>There is no evidence that the physician was informed that the patient did not receive home health aide services as ordered in the plan of care.</p> <p>There is no evidence that the agency provided the patient with a home health aide from admission to 12/11/07 when the patient was admitted to the hospital.</p> <p>On 02/22/08, the surveyor interviewed the DPS and Clinical Manager. The surveyor asked if this patient was readmitted to the agency after hospital discharge. The DPS stated that they felt that the patient was not safe to provide her own care.</p> <p>Home Visit</p> <p>5. Patient #20 was admitted to the agency on 01/21/08 with diagnoses of dementia, abnormality</p>	G 157	<p>See corrective action pg. 18/61 G157</p> <p>On 12/11/07 a letter was sent by the VNA to the hospital the patient was admitted to alerting the hospital that the patient lived alone and needed a higher level of care or admission to short term rehabilitation until medical status was more stable for home care intervention.</p> <p>See corrective action pg. 18/61 G157</p>		

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G 157	Continued From page 21 of gait, type II diabetes, a history of falls and spinal stenosis. The initial nursing assessment and plan of care indicated that the patient required a home health aide 2 hours a day twice a week for personal care, meal preparation and light housekeeping.  On 01/30/08, the skilled nurse documented that the patient was managing personal care but was at risk for falls. The skilled nurse documented that the patient had generalized weakness and was awaiting home health aide service.  On 02/07/08, the skilled nurse documented that "home health aide service no longer needed." From 01/21/08 to 02/07/08, there is no evidence that a home health aide was ever initiated.  This record was reviewed with the DPS and Clinical Managers on 04/03/08. No further information was provided.	G 157			
G 159	484.18(a) PLAN OF CARE  The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.  This STANDARD is not met as evidenced by: Based on a review of 42 clinical records, 25 observational home visits, and interviews with the Director of Patient Services (DPS), and Clinical	G 159	Staff will be educated on the development of the patient's plan of care and the need to include patient specific parameters July 31, 2008. By: Director of Clinical Operations  IDT Care Plans will be revised to ensure accurate plan of care and facilitate better communication among clinicians and better assessment and follow up for pain/pain management by July 31, 2008. By: Director of Clinical Operations	10/31/08	

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NAME OF PROVIDER OR SUPPLIER

VNA CENTRAL NEW YORK CHHA

STREET ADDRESS, CITY, STATE, ZIP CODE

1050 W GENESEE STREET  
SYRACUSE, NY 13204

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G 159	<p>Continued From page 22</p> <p>Managers, evidence is lacking in 29 records the plan of care developed is of sufficient scope to meet the patient's needs. Patients # 1, 2, 3, 4, 5, 6, 7, 10, 13, 14, 15, 18, 19, 21, 22, 23, 24, 25, 26, 28, 29, 30, 32, 34, 37, 38, 40, 41, 42.</p> <p>Failure to develop a complete and accurate plan of care has the potential for unmet patient needs and the potential for negative outcomes for the agency's patient population.</p> <p>1. In 4 of 5 clinical records reviewed for pediatric patients (# 9, 10, 24, 27, 28), evidence is lacking that the plan of care is of sufficient scope to ensure that the patient's needs are met. Patients # 10, 24, 28, 27.</p> <p>o Patient # 28 an eight month old child was admitted to the agency on 11/12/07 with a primary diagnosis of CNS Demyelination and secondary diagnoses of convulsions and failure to thrive. The plan of care fails to include the following:</p> <ul style="list-style-type: none"> <li>- a plan to assess seizure activity during each visit and parameters to notify the physician. Specifically, during the initial nursing assessment the skilled nurse documented that the patient has 6 to 8 seizures per day lasting 5 to 30 seconds.</li> <li>- plan to assess developmental status during each visit</li> <li>- accurate medication orders. Plan of care states phenobarbital 100 milligrams (mg) orally once daily afternoon dose, solution is 20 mg/5 milliliters (ml), patient gets 5 mls. Five mls of the phenobarbital is only 20 mg.</li> </ul>	G 159	<p>Clinician counseled in Comprehensive development of Plan of Care. Addendums to POC completed as appropriate for patient #1(d/c 5/14/08), 5, 4, 6, 21 (d/c 3/19/08), 23 (d/c 5/27/08), 34 (d/c 5/23/08).</p> <p>Clinician counseled in comprehensive development of the Plan of Care for patients #13 (d/c 3/18/08), 14 (d/c 3/13/08), 15 (d/c 4/18/08), 18 (d/c 4/14/08), 22, 26 (d/c 11/26/07), 29 (d/c 12/31/07), 30 (d/c 3/8/08), 38, 40 (d/c 12/10/07), and 41 (d/c 3/13/08).</p> <p>A new pediatric assessment too was developed in May of 2008 to assist the pediatric staff in completing an accurate assessment and developing an appropriate plan of care. The assessment tool includes a complete physical, psychological, social and developmental assessment to be used for all pediatric clients. The pediatric nurse will identify and document areas of deficiency and complete an accurate and appropriate plan of care. By: Clinical Nurse Manager</p> <p>All pediatric nurses will be educated on the use of the new pediatric assessment by the Clinical Nurse Manager by July 15, 2008.</p> <p>The Clinical Nurse Manager will ensure all pediatric nurses are competent in management of pediatric clients' medications.</p>	



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G 159	<p>Continued From page 23</p> <ul style="list-style-type: none"> <li>- a plan to assess/monitor phenobarbital level for patient having 6 to 8 seizures /day.</li> <li>- parameters to report weight changes either loss or gains</li> </ul> <p>This record was reviewed with the DPS and the Clinical Manager on 03/13/08. No further information was provided.</p> <p>o Patient # 24, a [REDACTED] was admitted to the agency on 01/17/07 with a primary diagnosis of cerebral palsy and secondary diagnoses of gastrostomy, asthma, ventricular shunt-abdomen. The CMS 485 plan of care dated 01/12/08 included orders for private duty nursing for licensed practical nursing (LPN) 5 days a week however, failed to include the following:</p> <ul style="list-style-type: none"> <li>- complete parameters for use of as needed albuterol 2.5 mg inhalation every 4 hours as needed for increased congestion via nebulizer failed to specify. The plan did not specify if the congestion was nasal, upper respiratory or lung congestion.</li> <li>- specifics related to the application of bacitracin ointment as needed. The medication order states use twice a day to the affected area, however, there is no indication what area is affected.</li> <li>- a plan to assess gastric feeding tube and care to be provided</li> <li>- direction for the nurse to assess seizure activity</li> </ul> <p>Additionally, there are discrepancies between the physician's plan of care (CMS-485) dated</p>	G 159	<p>By June 6, 2008 parameters for weight loss/gain for the pediatric patient will be obtained by the case manager from the physician. If the physician does not give parameters the agency standard parameters for the pediatric client will be used and entered in the Plan of Care for the physician's signature.</p> <p>Patient #24 is an active patient.</p> <p>Individual counseling was conducted with the case manager regarding nebulizer, albuterol treatments, g-tube site orders on the POC. Orders were clarified and corrected in May of 2008.</p> <p>Random audits will be completed quarterly per audit schedule. See page 60/61 G250.</p> <p>The Clinical Nurse Manager will ensure parameters for prn medication for pediatric patients are included in the medication orders by June 30, 2008.</p>		

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G 159	<p>Continued From page 24</p> <p>01/12/08 and the private duty nursing plan of care dated 07/20/07. The private duty nursing plan of care was not updated and directs the LPN to provide chest physiotherapy in the evening. Chest physiotherapy is not included on the CMS-485 dated 01/12/08.</p> <p>This record was reviewed with the DPS and the Clinical Manager on 04/08/08. No further information was provided.</p> <p>o Patient #10, a 6 day old infant, was admitted to the agency on 02/02/08 with diagnoses of fetal growth retardation and newborn feeding problems. The plan of care failed to include the following:</p> <ul style="list-style-type: none"> <li>- direction for the skilled nurse to weigh the patient at each visit</li> <li>- plan to assess growth and development milestones</li> </ul> <p>This record was reviewed with the DPS and the Clinical Manager on 03/14/08. No further information was provided.</p> <p>o Patient #27, a 7 year old child, was admitted to the agency on 12/28/04, with diagnoses of congenital hydrocephalus, ventricular shunt to the abdomen, convulsions and mental retardation. The plan of care for the certification period 12/10/07 to 02/07/08 failed to include the following:</p> <ul style="list-style-type: none"> <li>- orders for home health aide service</li> <li>- plan for skilled nurse to assess seizure activity</li> </ul>	G 159	<p>The Clinical Nurse Manager will ensure the Private Duty Nurse Care Plan is updated every 6 months and all treatments are included on the patient's Plan of Care or as an interim order for the physician's approval.</p> <p>All private duty Nurse Care Plans will be reviewed and revised as appropriate by June 30, 2008.</p> <p>Random audits will be completed quarterly per audit schedule. See page 60/61 G250.</p> <p>Patient #10 was discharged March 10, 2008.</p> <p>Patient #27 is active. The Case Manager and the Clinical Nurse Managers were counseled regarding the need to include seizure activity in Plan of Care as of June 18, 2008.</p>		

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G 159	<p>Continued From page 25</p> <ul style="list-style-type: none"> <li>- plan to assess swallowing ability On 11/28/07, the skilled nurse documented that the school nurse called the agency to inform the skilled nurse that the patient was gagging on his food. The skilled nurse failed to assess the patient's swallowing ability.</li> </ul> <p>This record was reviewed with the DFS on 03/13/08. No further information was provided.</p> <p>2. Patient # 42 was admitted to the agency on 03/27/08 with a primary diagnosis of lung cancer resulting in a left lower lobectomy and secondary diagnoses of asthma, ulcerative colitis and an ileostomy. The agency referral from the short term rehabilitation facility indicated that the patient needed skilled nursing, physical therapy, occupational therapy, and home health aide services. The plan of care failed to include the following:</p> <ul style="list-style-type: none"> <li>- plan to assess the patient's pain/pain management Specifically, the skilled nurse conducted an initial assessment visit and documented that the patient lived alone, and had constant pain with an intensity of 6 on a scale of 0 to 10. The skilled nurse documented that the patient stated "pain feels like barbed wire, on fire". Although the patient has an order for Dilaudid 4 mg every 4 hours as needed for pain, there is no plan to assess the patient's pain on subsequent skilled nursing visits or the use of as needed pain medication.</li> <li>- plan to meet the patient's personal care needs. The skilled nurse documented that she was unable to use the shower or tub; needs to be bathed in bed or bedside chair; transfers with assistance; is unable to prepare light meals;</li> </ul>	G 159	<p>Patient #42 was discharged April 23, 2008.</p>		

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G 159	<p>Continued From page 26</p> <p>unable to do laundry; or housekeeping. The skilled nurse documented that on 03/28/08 a different skilled nurse would visit the patient and determine the need for a home health aide. There was no skilled nursing visit until 04/01/08. During the visit the skilled nurse documented that the patient had dyspnea at rest and generalized decreased strength. The skilled nurse documented that the patient asked about a home health aide. The skilled nurse documented, "I explained nicely that with her apartment in disarray will be unable to place aide at this time". There was no plan developed to ensure that the patient's personal care needs were met.</p> <p>- plan to provide medical social work services. On 04/07/08, the occupational therapist documented a case conference with the skilled nurse regarding the need for a medical social worker (MSW). On 04/08/08, the agency received a prescription for a medical social work consultation. The skilled nurse documented in a telephone note to the clinical manager dated 04/08/08 that having a MSW would be a "duplication" of services.</p> <p>Although the agency received an order for medical social work services on 04/08/08, the agency failed to provide a social work evaluation and failed to develop a plan to meet this patient's medical social needs.</p> <p>This record was reviewed with the DPS and the Clinical Manager on 05/05/08. No further information regarding the plan of care was provided.</p> <p>Home Visit</p>	G 159	<p>By August 31, 2008 clinicians will be educated on completing an environmental assessment on the chronic care client with multiple social environmental needs and clients with psychiatric problems to ensure clients needs are met.</p> <p>By: Director of Clinical Operations</p> <p>Random audits will be completed quarterly per audit schedule. See page 60/61 G250.</p> <p>As of July 31, 2008 the Director of Clinical Operations will ensure an evaluation visit will be provided by all disciplines ordered by a physician. If services are not provided the physician will be notified as to why, and the case manager will complete an interim order for the physician's signature.</p> <p>Random audits will be completed quarterly per audit schedule. See page 60/61 G250.</p>		

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G 159	<p>Continued From page 27</p> <p>3. Patient #1 was admitted to the agency on 12/25/07 with a primary diagnosis of insulin dependent diabetes and secondary diagnoses of surgical amputation of toes on the left foot, vascular shunt and bypass chronic kidney disease. The initial nursing assessment indicated that the patient lives with her [redacted] had limited adult family to assist her. The skilled nurse documented that the patient had 4 wounds. Labeled wounds 1 - 4. The plan of care dated 12/25/07 failed to include the following:</p> <ul style="list-style-type: none"> <li>- wound care to be provided to all wounds. Specifically, there was no plan for wound care to wound # 1 and # 3. Additionally, wounds # 2 and # 4 lack direction to cleanse the wound during wound vac dressing changes ordered Monday, Wednesday and Friday.</li> </ul> <p>During an observational home visit conducted by the surveyor with the skilled nurse on 03/05/08, the skilled nurse cleansed the wound with normal saline after removal of old dressing.</p> <ul style="list-style-type: none"> <li>- plan to address safety issues identified during the initial nursing assessment. Specifically, the skilled nurse documented during the initial nursing assessment that the patient's door and lock were broken while she was in the hospital. There was no plan to ensure that the patient was safe at home.</li> <li>- plan to assess lower extremity edema identified during the initial nursing assessment.</li> </ul> <p>This record was reviewed with the DPS and the Clinical Manager on 03/14/08. No further information was provided.</p>	G 159	<p>Patient #1 was discharged May 14, 2008.</p> <p>By July 31, 2008 protocol will be developed which will allow clinicians to document of multiple wounds accurately and consistently in order to develop the Plan of Care.</p> <p>By: Director of Clinical Operations</p>		

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G 159	<p>Continued From page 28</p> <p>4. Patient # 32 was admitted to the agency on 01/18/08 with a primary diagnosis of vascular access catheter and secondary diagnoses removal of left knee hardware, removal of infected pacemaker/defibrillator, requiring intravenous antibiotics, and hypertension. The plan of care fails to include the following:</p> <ul style="list-style-type: none"> <li>- specific settings for the use of the "life vest" external defibrillator. The plan of care states life vest.</li> <li>- parameters for use of ice to the left knee. The plan of care indicates may use ice as needed</li> <li>- no plan to assess patient for signs and symptoms of urinary tract infections for a patient with a diagnosis of urinary tract infection in the hospital.</li> <li>- no plan to assess site of pacemaker removal.</li> </ul> <p>This record was reviewed with the DPS and the Clinical Manager on 04/01/08. No further information was provided.</p> <p>5. Patient # 19 was admitted to the agency on 02/08/08 with a primary diagnosis of neoplasm related pain and secondary diagnoses of metastatic cancer of the brain and spine, malnutrition and a decubitus ulcer of the lower back. The plan of care failed to include the following:</p> <ul style="list-style-type: none"> <li>- no plan to weigh patient with a diagnosis of malnutrition</li> <li>- no plan to provide care to the porta-cath.</li> </ul>	G 159	<p>Patient #32 discharged February 23, 2008.</p> <p>The clinician was counseled on May 20, 2008 by the Clinical Nurse Manager on including all information on the patient's plan of care.</p> <p>Staff will be educated as part of orientation and yearly thereafter, on policy and procedure, Completion of a Comprehensive Assessment including plan of care development. By: Director of Clinical Operations</p> <p>NB: There are no specific settings for use of "life vest" .</p> <p>Patient #19 was discharged on April 1, 2008.</p> <p>As of July 31, 2008 staff will be educated, as part of orientation and yearly thereafter, on policy and procedure, Completion of a Comprehensive Assessment and development of the Plan of Care. By: Director of Clinical Operations</p> <p>Random audits will be completed quarterly per audit schedule. See page 60/61 G250.</p>		

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G 159	Continued From page 29 This record was reviewed with the DPS and the Clinical Manager on 03/26/08. No further information was provided.	G 159		09/30/08	
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE  Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.  This STANDARD is not met as evidenced by: Based on a review of 42 clinical records, 25 observational home visits, interviews with agency staff and a review of agency policies and procedures, evidence is lacking in 23 clinical records that the skilled nurses identify the need to report changes in the patient's condition to the physician which may require a change in the plan of care. Patients #1, 2, 3, 7, 9, 12, 13, 20, 21, 22, 24, 25, 26, 28, 29, 30, 31, 32, 33, 35, 37, 40, 41.  Failure to notify the physician of changes in the patient's condition has the potential for unmet patient needs and negative outcomes for the agency's patient population.  1. Patient # 41 was admitted to the agency on 03/05/07 with a primary diagnosis of atrial fibrillation and secondary diagnoses of congestive heart failure and hypertension. During the initial nursing assessment the SN documented that the patient had 4 wounds identified as follows:  wound #1: described as a stage II pressure ulcer of the coccyx. This wound was not measured. wound #2: described as left chest wall pacer site measuring 5 cm wide	G 164	The Director of Clinical Operations will re-educate staff by June 30, 2008 on the need to alert the physician of any changes that need to alter the Plan of Care. Staff will be instructed in the use of the IDT Care Plan to view the current Plan of Care.  Clinicians were counseled on comprehensive assessments and ongoing reassessment with appropriate communication with the physician regarding changes in condition. Where appropriate, addendums to orders were completed for patient #1(d/c 5/14/08), 2, 3, 7, 9, 12(d/c 5/23/08), 21(d/c 3/19/08), 22, 24, 25, 28(d/c 2/18/08), 29(d/c 12/31/07), 30(d/c 3/8/08), 31(d/c 4/24/08), 32(d/c 2/13/08), 33(d/c 2/22/08), 35(d/c 3/17/08), 37(d/c 2/7/08)  Random audits will be completed quarterly per audit schedule. See page 60/61 G250.  Patient #41 was discharged March 31, 2008.		



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NAME OF PROVIDER OR SUPPLIER  VNA CENTRAL NEW YORK CHHA			STREET ADDRESS, CITY, STATE, ZIP CODE 1880 W GENESEE STREET SYRACUSE, NY 13204		
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G 154	<p>Continued From page 30</p> <p>wound #3: described as burn mark from resuscitation paddles sternum measuring 0.7 cm x 1.0 cm.</p> <p>wound #4: described as burn mark from resuscitation paddles sternum measuring 1.0 cm x 0.5 cm.</p> <p>- On 03/12/08, the SN visited the patient. During the visit the nurse identified that the patient had a temperature of 99.1, lung sounds on the left with wheezing and on the right diminished and sputum was brown in color. The SN observed the wound and documented that the wound was now 95% necrotic tissue and 5 % slough tissue. The wound was described as blackish in color with some green noted, and has a noticeable odor. The wound was also re-staged by the SN as a stage IV. The SN failed to measure the wound and documented that she was "unable to measure due to location, deep in gluteal folds".</p> <p>- On 03/12/08, the skilled nurse documented that she contacted the physician's office and reported the following: "c/lit (client) had low grade temp, wound is getting worse had crackles right lower base and left diminished." The SN failed to inform the physician that during her SN assessment on 03/12/08, she determined that the wound was now a stage IV increased from a stage II in just 7 days. There is also no evidence that the SN informed the physician that due to the location of the wound it was never measured.</p> <p>There was no follow-up communication with the physician to determine if changes in wound care were required.</p> <p>This record was reviewed with the Director of Patient Services, Clinical Manager, Tele-health</p>	G 154	<p>In May of 2008 individual clinicians were counseled and corrective action was taken by the Director of Clinical Operations regarding the need to report changes in clinical status to the physician and the Clinical Manager. The Case Manager was instructed in appropriate assessment of wounds and wound care protocol.</p> <p>In May of 2008 the Clinical Nurse Specialist conducted supervisory follow-up in the home to ensure clinical competency in wound care.</p> <p>Director of Clinical Operations will re-educate all clinical staff on wound protocol by July 31, 2008.</p> <p>Education will address appropriate follow up with the Plan of Care, appropriate assessment of wounds, and appropriate follow up with the physician including change in status and unresolved problems. Education will include instruction on the importance of timely notification to the physician with changes in patient status.</p> <p>Random audits will be completed quarterly per audit schedule. See page 60/61 G250.</p>		



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NAME OF PROVIDER OR SUPPLIER

VNA CENTRAL NEW YORK CHHA

STREET ADDRESS, CITY, STATE, ZIP CODE

1050 W GENESEE STREET  
SYRACUSE, NY 13204

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G 164	<p>Continued From page 31</p> <p>Coordinator and Administrator on 04/21/08. The DPS and Clinical Manager did not know why the skilled nurse did not contact the physician again to determine if there was a change in the plan of care when the wound deteriorated.</p> <p>2. Patient # 28 was admitted to the agency on 10/08/07 with diagnoses of chronic obstructive pulmonary disease and congestive heart failure. During the initial nursing assessment, the skilled nurse documented that the patient lives alone and needs the assistance of a home health aide. There is no evidence that the skilled nurse reported the following changes in the patient's condition to the physician:</p> <p>Specifically, patient was performing daily tele-health monitoring beginning on 10/09/07. The initial tele-health weight documented was 199 pounds. On 10/23/07, the skilled nurse documented that the patient's weight on the tele-health monitor was 190 pounds, this represents a 9 pound weight loss in 14 days. The physician was not notified.</p> <p>Additionally, during the initial nursing assessment the skilled nurse identified that the patient required a home health aide for personal care and to assist with meal preparation. On 10/17/07, the patient asked the nurse when her home health aide service was starting. The skilled nurse stated that the agency was having trouble finding one in her area. The skilled nurse did not assess the patient's ability to prepare her own meals and did not inform the physician that the patient was not receiving home health aide services as ordered.</p> <p>From 10/23/07 to 11/16/07, the patient lost</p>	G 164	<p>By July 31, 2008 the Director of Clinical Operations will review and revise Telehealth Policy regarding notification of the physician of change in patient's condition.</p> <p>See page 7/61 G143.</p> <p>Patient #26 was discharged November 26, 2007.</p> <p>In May of 2008 the Telehealth Nurse was counseled regarding the need to notify the physician of weight loss by the Director of Clinical Operations. See page 7/61 G143.</p> <p>By July 31, 2008 the Home Health Aide tracking policy will be reviewed and revised to include notification of the physician of no aide service available and the need for OT evaluation.</p> <p>By: Director of Clinical Operations</p> <p>See page 18/61 G157.</p>	07/31/08

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G 164	<p>Continued From page 32</p> <p>another 14.5 pounds. Although the tele-health nurse documented that she was aware that the patient's weight was down, she failed to contact the physician to report this change in condition.</p> <p>This record was reviewed with the DPS on 02/22/08. No further information was provided.</p> <p>3. Patient #40 was admitted to the agency on 11/30/07 with a primary diagnosis of malnutrition requiring total parental nutrition (TPN) via a peripherally inserted central catheter (PICC) and secondary diagnoses of anorexia, dehydration and dysphagia. During the initial nursing assessment, the skilled nurse documented that the patient lived alone and required the assistance of a home health aide for personal care. The SN also documented that the patient had a caregiver willing to learn to flush the PICC and administer the TPN.</p> <p>On 12/03/07, at 5:15 pm, the on call nurse received a call from the patient's caregiver stating that he was unable to flush the "grey port" and could not get a blood return. The SN documented that the caregiver was very upset and stated that he was no longer going to take care of the IV. He stated that he would hook up the TPN tonight and disconnect in the morning. The SN failed to inform the physician that one of the PICC line lumens was occluded or that the patient no longer had a willing and able caregiver.</p> <p>During the 12/04/07 visit, the SN documented that she and another nurse instructed the client on flushing, setting up and administering TPN. Client needs further instructions. The skilled nurse documented that one of the two PICC lumens is plugged and that the physician was</p>	G 164	<p>By July 31, 2008 the Director of Clinical Operations will reeducate staff and reinforce expectations of Plan of Care review to determine necessary changes in parameters and the expectation of appropriate and timely communication with the physician.</p> <p>Random audits will be completed quarterly per audit schedule. See page 60/61 G250.</p> <p>Patient #40 was discharged December 10, 2007.</p> <p>In March of 2008 The Director of Clinical Operations reviewed with on-call nurse the need to notify the physician of a change in the patient's status and the need to schedule a home visit to support the caregiver.</p> <p>See page 32/61.</p>		

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G 164	<p>Continued From page 33</p> <p>aware. There is however, no evidence that the SN informed the physician that the lumen was occluded.</p> <p>On 02/22/08, the surveyor interviewed the DPS and Clinical Manager. No further information regarding notifying the physician was provided.</p> <p>Home Visit</p> <p>4. Patient #13 was admitted to the agency on 01/01/08 with a primary diagnosis of foot ulcer and secondary diagnoses of type II diabetes and mild dementia. On admission the skilled nurse identified a diabetic foot ulcer on the plantar surface of the left great toe requiring DuoDerm dressing changes 3 days a week. On 1/08/08 the skilled nurse documented that the patient had 2 new wounds. One wound was located on the left foot and the other on the right foot. On 02/05/08, the skilled nurse noted that the patient's left foot toe wounds were 100% slough and had an odor. The patient was taken to the emergency room and returned home the same day with new wound care orders.</p> <p>On 03/08, 09, 10, 11/08, the skilled nurse documented that the wound drainage was purulent green or yellow. There was no call to the physician to report this change in the patient's condition and on 03/12/08, the patient was admitted to the hospital with a diagnosis of cellulitis</p> <p>Additionally, the skilled nurse failed to contact the physician to report a 19 pound weight loss from 01/01/08 to 02/13/08. On 01/01/08 the patient's weight was 179 pounds and on 02/13/08 the patient's weight was 160 pounds.</p>	G 164	<p>Patient #13 was discharged March 18, 2008.</p> <p>In May of 2008 the Clinician was counseled regarding wound protocol, review of the IDT Care Plan and proper, timely communication with the physician.</p> <p>By: Director of Clinical Operations</p>		

*6/18/08 Paul Julliansen*  
*acceptable*

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G 164	Continued From page 34  This record was reviewed with the DPS on 03/26/08. No further information was provided.  5. Patient # 20 was admitted to the agency on 01/21/08 with a primary diagnosis of Dementia and secondary diagnoses of abnormality of gait, type II diabetes and hypertension. During the initial nursing assessment the skilled nurse documented that the patient complained of burning upon urination. The skilled nurse failed to inform the physician of the urinary symptoms and directed the patient's daughter to call the physician.  On 01/23/08, the skilled nurse returned to assess signs and symptoms of a urinary tract infection and check if the patient's daughter called the physician. The skilled nurse documented that the patient had "urinary burning for 2 weeks. Daughter has yet to take a specimen to lab". The physician still was not consulted and no specimen obtained by the nurse.  There was no subsequent skilled nursing visit until 01/30/08 and no communication with the patient until the 01/30/08 skilled nursing visit, when the skilled nurse documented that "patient on antibiotic for UTI"  This record was reviewed with the DPS on 04/03/08. No further information was provided.	G 164	Patient #20 was discharged March 7, 2008.  In May of 2008 The Clinical Nurse Manager counseled the clinician regarding appropriate follow-up and notification of physician on a change in condition.		
G 171	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse makes the initial evaluation visit.	G 171	Individual clinicians were counseled on comprehensive nursing assessment and standards of practice based on agency policy and protocols for patient # 3, 6, 7, 12 (d/c 5/23/08), 14 (d/c 3/13/08), 16 (d/c 4/8/08), 18 (d/c 4/14/08), 19 (d/c 4/1/08), 20 (d/c 3/7/08), 23 (d/c 5/27/08), 24, 25, 26 (d/c 11/26/07), 28 (d/c 2/18/08), 29 (d/c 12/31/07), 31 (4/24/08), 32 (2/13/08), 39 (3/28/08)	10/31/08	

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G 171	<p>Continued From page 35</p> <p>This STANDARD is not met as evidenced by: Based on a review of 42 clinical records records and 25 observational home visits, interviews with the Director of Patient Services and Clinical Managers, evidence is lacking in 26 records that the initial nursing assessment is of sufficient scope to accurately identify the current needs of the patient. Patients # 1, 2, 3, 6, 7, 12, 14, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 28, 29, 30, 31, 32, 37, 39, 40, 41.</p> <p>Failure to conduct a complete and comprehensive initial nursing assessment may lead to unmet patient needs and has the potential for negative outcomes for the agency's patient population. *</p> <p>1. Patient # 41 was admitted to the home care agency on 03/05/08 with a pressure ulcer to the sacral area. On 03/05/08, the skilled nurse (SN) conducted an initial assessment. The initial nursing assessment failed to include the following:</p> <ul style="list-style-type: none"> <li>- a complete and accurate assessment of the patient's sacral pressure ulcer. Specifically the SN documented that the patient had a sacral pressure ulcer located on the patient's coccyx, however the skilled nurse documented the wound was not measured as client could not stand for an extended length of time and the wound was located deep in buttocks fold of coccyx. The skilled nurse failed to document the reason why the patient was unable to stand long enough to be assessed in the standing position or why the patient had to be assessed in the standing position. Although the skilled nurse documented she contacted the physician during the initial assessment and the physician approved</li> </ul>	G 171	<p>By July 31, 2008 staff will be educated on Comprehensive Nursing Assessment. Clinicians will be educated in standards of practice based on evidence based policy in the following area: Wound assessment and documentation, IV interventions, patient education and documentation, weight loss and appropriate interventions, initial nursing assessment and reassessment, neurological assessment, and pain assessment and documentation.</p> <p>By December 31, 2008 yearly skills competency test will be conducted in the identified areas of wounds, infection control, IV interventions, comprehensive assessment and notification of the physician.</p> <p>By August 31, 2008 revisions of documentation manual will be made to include instruction for each assessment area.</p> <p>By June 30, 2008 comprehensive audits will be performed by Quality Care Coordinator and Clinical Manager to ensure standards of practice are being followed. See page 60/61 G250. By: Director of Clinical Operations</p> <p>See corrective action page 30/61, patient#41</p>	

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G 171	<p>Continued From page 36</p> <p>DuoDerm to be applied to the area, the skilled nurse failed to inform the physician that she was unable to complete the wound assessment during the initial visit. Additionally, the SN failed to document what if any care was provided to pressure ulcer during the visit.</p> <p>- a complete and accurate assessment of the patient's bowel function. Specifically, the SN documented the patient had diarrhea six times, the SN failed to assess the last time the patient had diarrhea or if the patient was incontinent of stool.</p> <p>- a complete and accurate assessment of the patient's activities of daily living (ADL's). Specifically, the hospital referral stated that the daughter works during the day and the family was trying to arrange for 24 hour supervision. Evidence is lacking the skilled nurse assessed: whether the patient required 24 hour supervision; the amount of assistance/supervision the patient actually required to complete ADL's; who would be responsible for providing the assistance.</p> <p>Specifically, the skilled nurse documented on the initial assessment that the patient has urinary incontinence, wears depends in case of incontinence and changes depends when soiled. The skilled nurse failed to assess the patient's level of independence with this task since the skilled nurse also documented that the patient requires reminding, assistance, and supervision by another person to get to and from the toilet. The skilled nurse also failed to identify who would provide this supervision on a daily basis.</p> <p>Additionally, the skilled nurse documented on the initial assessment that the patient needs</p>	G 171			

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G 171	<p>Continued From page 37</p> <p>assistance with dressing the upper and lower body, requires the presence of another person through the bath for assistance or supervision, and preparation/reheating meals. Although the skilled nurse documented on the initial assessment that the family was willing to help with ADL's, the skilled nurse failed to assess the extent to which the family was willing and available to assist and supervise with bathing, toileting, dressing and meal preparation.</p> <p>- a complete and accurate assessment of the caregiver's knowledge and ability to manage equipment. Specifically, the skilled nurse documented on the initial assessment that the patient has oxygen delivered at 2 liter/minute by nasal cannula. Specifically, the skilled nurse failed to assess the family's knowledge of oxygen precautions and ability to regulate oxygen flow.</p> <p>This record was reviewed with the DPS and Clinical Managers on 04/21/08. No further information was provided.</p> <p>2. Patient # 40 was admitted to the agency on 11/30/08 with a primary diagnosis of malnutrition requiring the insertion of a peripherally inserted central catheter (PICC) for the infusion of total parental nutrition (TPN) and secondary diagnoses of dehydration, hypotension and depressive disorder. The initial nursing assessment failed to address the following:</p> <p>The skilled nurse failed to adequately assess patient's PICC line and TPN infusion as follows:</p> <ul style="list-style-type: none"> <li>- documentation of the size of the catheter</li> <li>- description of the type of dressing covering the</li> </ul>	G 171	<p>Patient #40 was discharged December 10, 2007.</p> <p>In March of 2008 the Clinical Nurse Manager counseled the clinician regarding PICC Line Policy and IV Infusion.</p>		

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G 171	<p>Continued From page 38 insertion site</p> <ul style="list-style-type: none"> <li>- clear documentation of the person responsible for initiating the TPN infusion. Specifically, the plan of care states that the TPN is to be administered over 12 hours at 130 cc/hour.</li> </ul> <p>There is no evidence that the TPN was initiated during the initial assessment visit or that a visit was planned within 12 hours to disconnect the TPN and flush the catheter.</p> <ul style="list-style-type: none"> <li>- clarification of the statement "both lines flushed" There is no indication of who flushed both lumens of the PICC and what solution was used.</li> <li>- complete assessment of the patient's ADL status. Specifically, the initial nursing assessment indicates that the patient lives alone and is unable to prepare light meals, is able to bathe in shower or tub with personal assistance and "expressed the need for a home health aide". There is no assessment of how the needs will be met.</li> </ul> <p>This record was reviewed with the DPS and Clinical Managers on 02/22/08. No further information was provided.</p> <p>3. Patient #22 was admitted to the agency on 01/15/08 with a primary diagnosis of regional enteritis and secondary diagnoses of hypertension, irritable bowel syndrome and insertion of a peripherally inserted central catheter (PICC) for the infusion of total parental nutrition (TPN). The the skilled nurse failed to assess the following:</p> <ul style="list-style-type: none"> <li>- complete assessment of the patient's abdominal wound identified as a midline</li> </ul>	G 171	<p>Patient #22 is an active patient.</p> <p>In May of 2008 the Clinical Nurse Manager reviewed with the clinician, PICC line procedure, IV infusion, wound care protocol, appropriate communication with the physician and the need for return demonstration of technique by caregiver.</p> <p>Random audits will be completed quarterly per audit schedule. See page 60/61 G250.</p>		

6/18/08 acc. Jgw



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G 171	<p>Continued From page 39</p> <p>abdominal fistula. Specifically, the skilled nurse documented that the wound has an ostomy bag in place. The skilled nurse failed to document the status of the patient's ostomy including the patient and /or caregiver's ability to change the ostomy bag. The skilled nurse documented that there was no drainage in the ostomy bag, however, did not assess the date when the ostomy was last emptied or changed.</p> <ul style="list-style-type: none"> <li>- complete and accurate description of the patient's gastrointestinal system. Specifically, the patient was admitted to the agency with a primary diagnosis of enteritis and irritable bowel. The assessment describes the patient's bowel status as "within normal limits", and that the "client denies having above symptoms at this time". There are no symptoms described in the record and no description of the patient's bowel movement including consistency.</li> <li>- complete assessment of the patient's PICC. Specifically, the skilled nurse documented that the PICC line is located in the patient's right arm. There was no assessment of the number of lumens, the size of the PICC, or an observation of the patient/caregiver's ability to infuse the TPN and/or flushing the catheter. The skilled nurse documented that "instruction on TPN set up and administration given", there is no documentation that the patient/caregiver competence was achieved.</li> <li>- assessment of the patient/caregiver's ability to provide PICC line care including flushing the catheter and infusing the TPN.</li> </ul> <p>This record was reviewed with the DPS and Clinical Managers on 04/02/08. No further</p>	G 171	<p>By August 31, 2008 the Documentation Manual will be revised to instruct clinicians to clearly identify when there are system assessments with no deficiencies. Staff will be instructed to document that the patient denies symptoms of specific systems. By: Director of Clinical Operations</p> <p>NB: Current electronic medical record interface list specific symptoms but do not print on hard copy unless they are indicated as occurring.</p>		

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NAME OF PROVIDER OR SUPPLIER

VNA CENTRAL NEW YORK CHHA

STREET ADDRESS, CITY, STATE, ZIP CODE

1050 W GENESEE STREET  
SYRACUSE, NY 13204

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G 171	<p>Continued From page 40 information was provided.</p> <p>4. Patient # 21 was admitted to the agency on 01/28/08 with a primary diagnosis of care following removal of a brain tumor and secondary diagnoses of aphasia, hypertension, diabetes, decubitus ulcer of the buttocks and insertion of an indwelling foley catheter. The skilled nurse failed to assess the following:</p> <ul style="list-style-type: none"> <li>- complete assessment of the patient's neurological status including the patient's hand strength. Specifically, the skilled nurse documented that the patient had limited range of motion in the extremities both upper and lower however, the skilled nurse failed to assess the strength and/or equality of the patient's hand grasps.</li> <li>- complete assessment of the patient's nutritional status including the physical ability to eat. Specifically, the initial nursing assessment indicates that the patient requires either "meal set-up, or intermittent assistance or supervision; or a liquid, pureed or ground meat diet". The documentation does not clearly indicate the patient's deficit.</li> <li>- complete assessment of the patient's integumentary system. Specifically, the skilled nurse documented in the initial nursing assessment that the patient had one pressure ulcer with a non-removable dressing. There is no documentation of the location of this wound or the type of dressing in place that is non-removable.</li> <li>- an assessment of the patient and caregiver's knowledge regarding methods to alleviate pressure to the wound.</li> </ul>	G 171	<p>Patient #21 was discharged March 19, 2008.</p> <p>In May of 2008 the Clinical Manager counseled the clinician on how to complete a neurological assessment, nutritional assessment, integumentary assessment, and wound protocol.</p> <p>Director of Clinical Operations will revise the Neuro Care Plan in electronic medical record to reflect a more thorough assessment by June 30, 2008.</p>	

*6/18/08 Paulina Williams  
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G 171	<p>Continued From page 41</p> <p>This record was reviewed with the DPS and Clinical Managers on 04/01/08. No further information was provided.</p> <p>5. In 13 of 13 clinical records reviewed where the skilled nurse identified that the patient was having pain, evidence is lacking that the skilled nurse adequately assessed the patient's pain/pain management. Patients # 1, 2, 3, 16, 18, 19, 20, 26, 29, 30, 31, 37, 39.</p> <p>- Patient # 37 was admitted to the agency on 01/24/08 with a diagnosis of damaged pelvic joint post-partum and intravenous antibiotics for septicemia. The skilled nurse documented during the initial nursing assessment that the patient was experiencing constant back, pelvic, and leg pain with a pain intensity level of 8 on a scale of 0 to 10. The skilled nurse documented that the "medication helps give some relief", however, it is unclear when the patient took her last dose pain medication or what the patient was taking for pain.</p> <p>This record was reviewed with the DPS and Clinical Managers on 03/26/08. No further information was provided.</p> <p>- Patient #29 was admitted to the agency on 12/03/07 with a primary diagnosis of chronic pain due to trauma. The skilled nurse documented in the initial nursing assessment that the patient was experiencing constant pain in her head, neck, shoulder, and back that ranges in intensity level from 6 to 7 on a scale of 0 to 10. The skilled nurse documented that the patient took pain meds "shortly before home visit". There is no</p>	G 171	<p>By June 30, 2008 the Director of Clinical Operations will re-educate staff in pain assessment to include review of most recent dosage of pain medication and its effectiveness.</p> <p>By June 30, 2008 the Director of Clinical Operations will re-educate staff to recognize signs and symptoms of drug addiction.</p> <p>Random audits will be completed quarterly per audit schedule. See page 60/61 G250.</p> <p>Patient #37 was discharged February 2, 2008.</p> <p>In May of 2008 the Clinical Nurse Managers counseled each clinician regarding comprehensive pain assessment and need to notify the physician of pain issues.</p> <p>Patient #29 was discharged December 31, 2007.</p>		

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G 171	<p>Continued From page 42</p> <p>assessment of the pain medications that the patient is taking.</p> <p>This record was reviewed with the DPS and Clinical Managers on 02/22/08. No further information was provided.</p> <p>- Patient #1 was admitted to the agency on 12/25/07 following an amputation of toes on the left foot. The skilled nurse documented in the initial nursing assessment that the patient was experiencing constant, throbbing leg pain with a pain intensity of 7 on a scale of 0 - 10. The skilled nurse documented that the pain was relieved by Percocet, rest and elevation, however, the assessment does not indicate the frequency that the patient uses Percocet.</p> <p>This record was reviewed with the DPS and Clinical Managers on 03/14/08. No further information was provided.</p> <p>- Patient #2 was admitted to the agency on 12/07/07 following extensive abdominal surgery. The skilled nurse documented during the initial nursing assessment that the patient was experiencing a constant sharp abdominal pain with a pain intensity of 5 on a scale of 0 - 10. The skilled nurse documented that the patient was taking Lortab Elixir with relief, however the assessment does not indicate the patient's last dose of the Lortab or the frequency that the patient uses this medication.</p> <p>This record was reviewed with the DPS and Clinical Managers on 04/10/08. No further information was provided.</p>	G 171	<p>Patient #1 was discharged May 14, 2008.</p> <p>Patient #2 is an active patient.</p> <p>The individual clinician was counseled regarding pain assessment and appropriate documentation.</p> <p>See page 42/61 regarding plan for reeducation.</p>		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE	G 172			10/31/08

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G 172	<p>Continued From page 43</p> <p>The registered nurse regularly re-evaluates the patients nursing needs.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 42 patient records, 25 observational home visits, policy and procedures and interviews with the Director of Patient Services (DPS), evidence is lacking in 35 records that skilled nursing reassessments identify the patient's current status and potential for changes in the care needs. Patients # 1, 2, 3, 5, 6, 7, 8, 9, 12, 13, 14, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 37, 39, 40, 41, 42.</p> <p>Failure to ensure that the skilled nursing reassessments identify the current status of the patient has the potential for unmet patient needs and the potential for negative outcomes for the agency's patient population.</p> <p>1. Patient #40 was admitted to the agency on 11/30/07 with a primary diagnosis of malnutrition requiring total parental nutrition (TPN) via a double lumen peripherally inserted central catheter (PICC) and secondary diagnoses of anorexia, dehydration and dysphagia. The skilled nurse (SN) failed to perform complete and accurate re-assessments to ensure that the patient's needs are being met. Specifically, evidence is lacking that the skilled nurse provided adequate teaching and assessment of the patient's ability to flush the PICC catheter and administer TPN.</p> <p>On 12/03/07, at 5:15 pm, the on call nurse</p>	G 172	<p>Individual clinicians were counseled on comprehensive reassessment and standards of practice based on agency policy and protocols for patient # 1 (d/c 5/14/08), 2, 5, 6, 7, 8, 9, 12 (d/c 5/23/08), 14 (d/c 3/13/08), 16 (d/c 4/8/08), 19 (d/c 4/1/08), 20 (d/c 3/7/08), 21 (d/c 3/19/08), 22, 23 (d/c 5/27/08), 24, 25, 26 (d/c 11/26/07), 28 (d/c 2/18/08), 30 (d/c 3/8/08), 31 (4/24/08), 32 (2/13/08), 39 (3/28/08), 42 (d/c 4/23/08)</p> <p>By June 30, 2008 staff will be instructed to review and update Interdisciplinary Team Care Plan at every visit and as necessary due to changes in client's status. Staff will be educated on Care Plan Documentation and Management. Staff will be educated on assessment requirements for home visits.</p> <p>Random audits will be completed quarterly per audit schedule. See page 60/61 G250.</p> <p>By: Director of Clinical Operations</p> <p>Patient #40 was discharged December 10, 2007.</p> <p>The Clinical Nurse Manager counseled clinician on PICC line and IV infusion therapy policy including re-assessment of care needs and appropriate notification of physician.</p>		

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G 172	<p>Continued From page 44</p> <p>received a call from the patient's caregiver stating that he was unable to flush the "grey port" and could not get a blood return. The SN documented that the caregiver was very upset and stated that he was no longer going to take care of the IV. He stated that he would hook up the TPN tonight and disconnect in the morning. The SN failed to conduct an assessment visit to assess the patency of the PICC line and in fact did not visit the patient until 10:15 am on 12/04/07.</p> <p>During the 12/04/07 visit, the SN documented that she and another nurse instructed the client on flushing and setting up and administering TPN. Client needs further instructions. The skilled nurse left the patient to administer her TPN and flush her PICC. However, failed to provide a follow-up visit or communication with the patient to ensure that the patient was independent with flushing the catheter.</p> <p>There was no skilled nursing visit until 12/05/07 at 06:30 pm. The SN visited the patient only after the patient called the SN and reported that she could not administer the TPN. The SN documented that the 2nd lumen of the PICC was hard to flush and had no blood return. During the visit, the SN asked the patient to describe her method of flushing the PICC line. The patient told the SN that she was flushing with heparin then normal saline. The plan of care indicates to flush with normal saline then heparin.</p> <p>On 12/07/07, the SN visited the patient and documented "new PICC placed today, non functioning, placed in same area as previous"</p> <p>The SN failed to assess the number of lumens, the size of the catheter or the patency of the</p>	G 172			

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G 172	<p>Continued From page 45</p> <p>lumens. The SN documented that the patient's granddaughter was receiving instructions regarding flushing the PICC line and administering the TPN. There is no assessment of the granddaughter's independence with the care of the PICC line and TPN administration.</p> <p>The on-call nurse documented a "Telephone Note" stating that the SN requested an evening visit to ensure that the patient was able to administer her TPN. No visit was conducted until 12/08/07. The next visit documented was conducted on 12/08/07 at 4 pm.</p> <p>On 12/09/07, the SN documented that the patient was alone during the visit and will not have her granddaughter to assist her with TPN care. The skilled nurse failed to assess the patient's competence with TPN administration and PICC care.</p> <p>From 12/3/07 when the patient's caregiver refused to provide care to 12/10/07 the last skilled nursing visit, the SN failed to ensure that the patient was competent to administer TPN and flush the PICC.</p> <p>On 12/11/07, the skilled nurse documented that the patient was transferred to the hospital due to abnormal labwork. When the patient was scheduled for discharge home from the hospital, the agency failed to resume care to the patient.</p> <p>During an interview with the DPS on 02/22/08, the surveyor asked the DPS why they did not readmit the patient to the agency. The DPS stated that the patient was unsafe at home because she did not have a caregiver to administer her TPN. The skilled nurse did not adequately assess the</p>	G 172	<p>In May of 2008 the Clinical Nurse Manager counseled the clinician on need to include return demonstration by caregiver to assess competency.</p> <p>In March of 2008 the Director of Clinical Operations counseled the on-call nurse. See page 33/61.</p> <p>The Director of Clinical Operations revised the Documentation of Patient Hospitalization Policy to reflect patients needs cannot be met by home care.</p>		

*acceptable for 1/18/08*

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G 172	<p>Continued From page 46</p> <p>patient's needs post hospitalization prior to making a determination that they would not re-admit the patient.</p> <p>2. Patient # 41 was admitted to the agency on 03/05/08 with a primary diagnosis of atrial fibrillation and secondary diagnoses of congestive heart failure and hypertension. During the initial nursing assessment the SN documented that the patient had 4 wounds identified as follows:</p> <p>wound #1: described as a stage II pressure ulcer of the coccyx.</p> <p>wound #2: described as left chest wall pacer site measuring 5 cm wide</p> <p>wound #3: described as burn mark from resuscitation paddles sternum measuring 0.7 cm x 1.0 cm.</p> <p>wound #4: described as burn mark from resuscitation paddles sternum measuring 1.0 cm x 0.5 cm.</p> <p>The skilled nurse failed to adequately assess the patient's coccyx wound including measurements:</p> <ul style="list-style-type: none"> <li>- on 03/06/08, the skilled visited the patient to apply DuoDerm to the patient's stage II coccyx wound. The skilled nurse documented that the patient's wound bed was 100% slough. The skilled nurse still did not take the opportunity to measure the wound before applying DuoDerm. Additionally, the SN documented instructing the clients daughter and sister about changing the DuoDerm. There is no evidence that the daughter was is independent in this task.</li> <li>- on 03/09/08, a SN visit was conducted for wound care, however, there is no assessment of the wound including measurements or a</li> </ul>	G 172	<p>Patient #41 was discharged March 18, 2008.</p> <p>The Clinical Nurse Manager counseled the clinician regarding re-assessment protocols and the need for return demonstration by caregiver.</p> <p>The clinician was counseled specifically regarding how to properly assess wounds and how to measure and document wounds.</p>		



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G 172	<p>Continued From page 47 description of the wound bed.</p> <p>On 03/11/08, a different SN visited the patient. During the visit the SN documented that the patient's temperature was 100.0 degrees and the patient's lung sounds on the left were diminished, she is using 2 liters nasal cannula and was having constipation. Although the SN documented that the daughter noted an odor during wound care, the SN did not remove the dressing or observe the wound. Although the SN called the physician the record is unclear if the SN reported the daughter's report of a foul odor from the wound.</p> <p>On 03/12/08, the SN visited the patient. During the visit the nurse identified that the patient had a temperature of 99.1, lung sounds on the left with wheezing and on the right diminished and sputum was brown in color. The SN observed the wound and documented that the wound was now 95% necrotic tissue and 5 % slough tissue. The wound was described as blackish in color with some green noted, and has a noticeable odor. The wound was also re-staged by the SN as a stage IV. The SN failed to measure the wound and documented that she was "unable to measure due to location, deep in gluteal folds".</p> <p>The SN documented that she contacted the physician's office to report that the patient had a low grad temperature and that the wound was getting worse.</p> <p>There was no skilled nursing visit and no contact with the patient until 03/18/08 at 1 pm, when the SN documented on a Telephone Note"called client, spoke with the daughter who states SN could not come today as another home care</p>	G 172			

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G 172	<p>Continued From page 48</p> <p>agency was coming to change her dressing." This was the first patient communication by the skilled nurse since 03/12/08.</p> <p>This record was reviewed with the Director of Patient Services, Clinical Manager, Tele-health Coordinator and Administrator on 04/21/08. The DPS and Clinical Manager did not know why the skilled nurse did not provide an adequate assessment of the patient's wound and provided no further information.</p> <p>3. Patient # 13 was admitted to the agency on 01/01/08 with a primary diagnosis of a foot ulcer and secondary diagnoses of type II diabetes, senile dementia, and congestive heart failure. The patient resides in an Senior Housing apartment and receives care from the Enriched Housing for meals and medication assistance. During the initial nursing assessment, the SN documented that the patient had a single wound described as a diabetic ulcer on the plantar surface of the left great toe measuring 1 cm x 0.8 cm. The skilled nurse failed to consistently describe the patient's wounds:</p> <p>On 01/08/08, the SN visited the patient to change the DuoDerm to the patient's diabetic foot ulcer. The visit documentation indicated that the patient now had three wounds as follows:</p> <ul style="list-style-type: none"> <li>- wound #1: located on the left great toe plantar surface</li> <li>- wound #2: located on the left 2nd toe</li> <li>- wound #3: located on the right foot 5th toe.</li> </ul> <p>None of the wounds were measured. The SN also failed to document the status of the patient's edema.</p>	G 172	<p>Patient #13 was discharged on March 18, 2008.</p> <p>In May of 2008 the Clinical Nurse Manager counseled and re-educated the clinician on wound care protocols.</p> <p>See page 34. Patient #13.</p>		

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G 172	<p>Continued From page 49</p> <p>The plan of care included SN visits every 3 to 5 days to change DuoDerm dressing from 01/01/08 to 02/06/08.</p> <p>Skilled nursing visits conducted on 01/15, 18, and 22/08 lacked an assessment of all three wounds. Only 2 wounds were identified during each of these visits.</p> <p>On 01/25/08, wound #1 was measured and noted as the left great toe wound. Wound #2 was now identified as the left chest wall wound, where a new pacemaker was placed and a dressing was intact. There was no assessment of the left 2nd toe wound or the right 5th toe wound.</p> <p>On 01/29/08, the SN described 2 wounds both located on the left foot. No wound on the right foot.</p> <p>Subsequent skilled nursing visit documentation inconsistently described the wounds making it unclear if the patient has 3 wounds and if the skilled nurse is providing care to all three wounds.</p> <p>This record was reviewed with the DPS and clinical manager on 03/26/08. No further information was provided.</p> <p>4. Patient #27, a [REDACTED] was admitted to the agency on 10/20/04 with a diagnosis of congenital hydrocephaly and a history of convulsions and developmental disabilities. Additionally, the patient had a ventricular shunt placed for obstructive hydrocephalus. The skilled nurse failed to consistently perform complete and accurate assessments as follows:</p>	G 172	<p>Patient #27 is an active patient.</p> <p>The Clinical Nurse Manager counseled the clinician in performing assessment of and documenting on nutritional status, weight, and contacting the physician regarding patient status.</p>		

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G 172	<p>Continued From page 50</p> <ul style="list-style-type: none"> <li>- a complete assessment of the patient's neurological status. Specifically, the 10/11/07, 12/10/07, and 02/08/08 plans of care included seizure precautions and instructions for the skilled nurse to call the physician for a shunt malfunction. The nurse failed to assess for seizures or for signs of increased intracranial pressure that might indicate a malfunctioning shunt during home visits conducted on 10/11/07, 10/26/07, 11/09/07, 11/28/07, 12/21/07, 12/31/07, 01/24/08, 02/07/08, 02/29/08.</li> <li>- an assessment of the patient's use of as needed Albuterol nebulizer. Specifically, on 12/31/07 and 01/24/08, the skilled nurse failed to document the frequency the patient uses the medication.</li> <li>-an assessment of the patient's circumcision site. Specifically on 12/31/07, the skilled nurse documented that the mother would not allow the nurse to check the patient's circumcision site because she did not want the patient disturbed during the visit, however, the skilled nurse never made a follow-up visit to reassess the patient's circumcision.</li> <li>-a complete and accurate assessment of the patient's nutritional status, weight and swallowing ability. Specifically: <ul style="list-style-type: none"> <li>on 10/11/07, the skilled nurse documented the patient's weight was 33 pounds and 7 ounces, had delayed and difficult swallowing, had a fair appetite and was on a regular diet, however, the skilled nurse also documented that the patient's diet was pureed diet/ Ensure puddings. The skilled nurse failed to assess if the patient was able to swallow regular food, pureed foods or puddings.</li> </ul> </li> </ul>	G 172	<p>The pediatric assessment was revised and will be implemented by July 15, 2008. See page 23/61 and 24/61.</p> <p><i>accept.</i> <i>PW</i> <i>6/18/08</i></p>		

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G 172	Continued From page 51  on home visits 10/26/07 and 11/09/07, the SN in accurately recorded the patient's weight in milligrams and not pounds and failed to observe for delayed or difficult swallowing as per the previous nurse's assessment.  on 11/28/07, an SN conducted a nursing visit. The SN inaccurately documented the patient's weight was 34.12 milligrams instead of pounds and that the patient's school called the agency stating the patient was gagging. The SN failed to observe the patient swallowing or eating food. Additionally, although the SN reported to the case manager, there is no documentation of what she actually reported.  the skilled nurse failed to follow-up with the patient for 20 days. On 12/29/07, the skilled nurse documented the patient's weight was 32.8 pounds and the patient was taking ensure puddings ad lib and blended foods, and had a fair appetite, however the skilled nurse failed to assess how much food the patient was able to take or assess for gagging or swallowing difficulties. During subsequent skilled nursing visits conducted from 12/29/08 through 02/29/08, the skilled nurse failed to assess swallowing or gagging.  on 12/31/07, the skilled nurse documented the patient had a poor appetite but was taking pureed/soft foods and ensure ad lib, however, the skilled nurse failed to assess how much food the patient was actually taking.  there was no skilled nursing follow-up for 24 days. On 01/24/08, the skilled nurse documented that the patient's weight was 31 pounds, a loss	G 172			

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G 172	<p>Continued From page 52</p> <p>of 2.7 pounds in 15 weeks. Although the skilled nurse documented that the patient's appetite was fair, the skilled nurse failed to assess how much food the patient was taking. Additionally, although the skilled nurse identified that the patient had a slight weight loss and encouraged the caregivers to make certain that the patient receives ensure puddings and other high caloric food, the skilled nurse failed to assess whether the patient was able to adequately swallow the puddings.</p> <p>This record was reviewed with the DPS and Clinical Managers on 03/13/08. No further information was provided.</p> <p>In 15 of 15 clinical records reviewed evidence is lacking that the skilled nurse is providing a comprehensive reassessment of the patient's pain and pain management during reassessment visits. Patients #1, 2, 3, 6, 8, 16, 18, 19, 21, 23, 29, 31, 37, 39, 42.</p> <p>o Patient # 29 was admitted to the agency on 12/03/07 with a diagnosis of chronic pain due to trauma. During the initial nursing assessment the skilled nurse documented that the patient had 3 areas of pain:</p> <ul style="list-style-type: none"> <li>- head/neck with an intensity of 6 on a scale of 0 to 10</li> <li>- shoulder with an intensity of 6 out of 10</li> <li>- back pain that radiates down both legs with numbness and tingling and a pain intensity of 7 out of 10.</li> </ul> <p>During weekly skilled nursing visit, the SN failed to consistently assess the patient's pain location and use of as needed pain medication:</p>	G 172	<p>Patient #29 was discharged on December 31, 2007.</p> <p>The Clinical Nurse Manager counseled the nurse on re-assessment of pain, documentation, and the need to notify the physician. See page 30/61 and 42/61.</p>		

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G 172	<p>Continued From page 53</p> <ul style="list-style-type: none"> <li>- on 12/06/07, the skilled nurse documented that the patient had back pain of 6 out of 10. The skilled nurse did not document the patient's use of as needed pain medication or an assessment of the patient's head/neck and shoulder pain identified on admission.</li> <li>- on 12/14/07, the skilled nurse documented that the patient had hip pain bilaterally with a pain intensity of 5 on a scale of 0 to 10 and takes perocet and Advil as needed. There was no assessment of when the patient's last dose was taken. The nurse also documented the head and neck pain of 4 out of 10. There was no assessment of the patient's last dose of pain medication.</li> <li>- on 12/21/07, the skilled nurse only assessed the patient's back pain with a pain intensity of 5 out of 10. There was no assessment of the frequency with which the patient takes his pain medication.</li> <li>- on 12/26/07, the skilled nurse assessed the patient's back pain with a pain intensity of 5 out of 10. There is no assessment of the patient's use of pain mediation or if the patient's other sites of pain were resolved.</li> </ul> <p>On 01/08/08, the clinical record contained a Transfer OASIS document indicating that the patient was admitted to the hospital for uncontrollable pain and a psychotic episode.</p> <p>On 02/22/08, the surveyor met with the DPS to review the findings of the clinical record review. The DPS stated that the nurse who completed the Transfer OASIS incorrectly documented that the transfer to the hospital was not for emergent care</p>	G 172			

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G 172	<p>Continued From page 54 but, for a scheduled admission.</p> <p>Home Visit</p> <p>o Patient #3 was admitted to the agency on 12/04/07 with a primary diagnosis of congestive heart failure and secondary diagnoses of insulin dependent diabetes with neuropathy, and osteoarthritis. During the initial nursing assessment the skilled nurse documented that the patient takes her pain medication which gives her some relief. During weekly SN visits the skilled nurse failed to assess the patient's use of as needed pain medication.</p> <p>Specifically on 12/20/07, a resumption of care assessment was completed. The skilled nurse documented that the patient had pain in her back and legs stating that she was unable to describe only that she had it all the time. There was no assessment of the patient's use of as needed pain medication.</p> <p>- on 12/22/07, at 2:30 am, the patient's family called the on-call nurse stating that "she (patient) is in a lot of pain". The on-call nurse directed the patient to take her Tylenol with Codeine. At 09:30 am, the patient's family again called the on-call nurse stating that the patient should take her pain medication and if no relief to call back. The on-call nurse advised the family that "patient needs to help herself in order to help her self". The on-call nurse did not speak to the patient regarding the intensity of the patient's pain or visit the patient to assess the pain.</p> <p>- on 12/23/07 at 11:15 am, a visit was conducted by the SN. The SN noted that the patient had constant leg pain with an intensity of 5 on a scale</p>	G 172	<p>Patient #3 is an active patient.</p> <p>In May of 2008 the Clinical Nurse Manager counseled the clinician on pain re-assessment, documentation and the need to notify the physician.</p> <p>In April of 2008 the Director of Clinical Operations counseled the on-call nurse regarding the need for a thorough pain assessment including home visits as indicated.</p>		

*6/18/08 acceptable*  
*Paula Williams RN*



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G 172	<p>Continued From page 55</p> <p>of 0 to 10. The SN did not specify which leg; location of the leg pain; or the patient's use of as needed Tylenol with Codeine for pain. There is no documentation that the SN was aware of the phone call received on 12/23/07 by the on-call nurse.</p> <p>This record was reviewed with the DPS and Clinical Managers on 04/03/08. No further information was provided.</p> <p>Home Visit</p> <p>o Patient # 18 was admitted to the agency on 12/21/07 with a primary diagnosis of ulcer of lower limb and a osteoarthritis. The skilled nurse failed to consistently assess the patient's pain or use of pain medications.</p> <p>- on 01/11/08, the skilled nurse documented that the patient was having constant pain. The skilled nurse failed to document the location of the pain or the frequency that the patient uses her medication. Additionally, the clinical record contained an order dated 01/11/08 to apply a 5 % Lidoderm patch to her lower back on for 12 hours then off for 12 hours. There was no assessment of the patient's use of this pain medication.</p> <p>During weekly skilled nursing assessment visits from 01/11/08 to 03/05/08, the skilled nurse failed to consistently assess the patient's use of the Lidoderm patch.</p> <p>Specifically, an observational home visit was conducted by the surveyor with the skilled nurse on 03/05/08. During the visit the skilled nurse asked the patient to describe her pain intensity level using a scale of 0 to 10. The patient stated</p>	G 172	<p>Patient #18 was discharged April 14, 2008.</p> <p>In May of 2008 the Clinical Nurse Manager counseled the clinician regarding comprehensive re-assessment, follow-up, pain management and documentation.</p>	

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G 172	Continued From page 56 that her pain was in her back and that as long as she was just sitting, the pain was 5 out of 10 and that if she had to get up to walk around the pain would be 8 out of 10. The patient stated that she only takes her Tylenol Arthritis for her pain.  At the conclusion of the visit, the surveyor asked the patient if it would be okay to review her current medications with the skilled nurse. The patient agreed. While reviewing the patient's medication, the surveyor noted that the patient had a box of Lidoderm 5% patches in her cupboard. The surveyor asked the skilled nurse if the patient was using the patches. The skilled nurse stated that she was unaware that the patient had Lidoderm patches ordered.  Furthermore, the surveyor asked the skilled nurse the frequency with which she reviews the patient's medications. The skilled nurse stated that she only reviews the medications once a month but, asks the patient if there have been any changes during the visit.  This record was reviewed with the DPS and Clinical Managers on 03/14/08. The DPS stated that the medications should be reviewed with the patient at every visit. No further information was provided.	G 172	In May of 2008 the Clinical Nurse Manager re-instructed the clinician on the need to review medication on every visit.  <i>OK</i>  <i>acceptable</i> <i>6/18/08</i> <i>PM</i>	
G 174	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse furnishes those services requiring substantial and specialized nursing skill.  This STANDARD is not met as evidenced by: See G121	G 174		

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G 245	<p><b>484.52 EVALUATION OF THE AGENCY'S PROGRAM</b></p> <p>The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient.</p> <p>This STANDARD is not met as evidenced by: Based on a review of: the agency's 09/10/07 Annual Program Evaluation, Professional Advisory Committee (PAC) meeting minutes for 2007, and Continuous Quality Improvement (CQI) clinical record audits records, evidence is lacking that the information used to evaluate the Agency's Program Evaluation is of sufficient scope to determine the extent that the agency's services are appropriate, adequate, effective and efficient.</p> <p>Specifically, a review of Agency's Annual Program Evaluation dated 09/10/07 includes reports from the following committees:</p> <ul style="list-style-type: none"> <li>- Personnel Committee</li> <li>- Finance Committee</li> <li>- Professional Advisory Committee</li> <li>- Planning Committee</li> <li>- Executive Committee</li> </ul> <p>The Agency Evaluation report begins with a summary of the findings of each committee. The only committee that addresses the quality of patient care is the Professional Advisory Committee. The Professional Advisory Committee reported that there were no recommendations and that medical record audit was completed and reviewed.</p>	G 245	<p>The agency annual evaluation will be reviewed by August 31, 2008 to expand the scope of CQI content including previous PAC reports and trends identified by audits. Quality Improvement trends, results and recommendations reported to CQI and PAC will be made available for the annual agency evaluation.</p> <p>By: President/CEO</p> <p><i>6/18/08 acceptable to [signature]</i></p> <p><i>016</i></p>	

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G 245	<p>Continued From page 58</p> <p>Further review of this document identified the extent of the medical record audits completed by the sub-committee. The sub-committee reviewed a total of 4 records. Two(2) audits were focused audits on medication management. One (1) audit was an active case with multiple disciplines and one (1) was a discharged case with nursing and tele-health.</p> <p>The medication management audits indicated that the medication assessments were complete and accurate. The Record Audit findings found only issues with coordination of care, teaching and patient outcomes.</p> <p>There is no evidence that the sub-committee reviewed the on-going Quality Improvement activities of the Continuous Quality Improvement (CQI) committee. This committee performs clinical record audits, trends the information and reports to the PAC on a quarterly basis.</p> <p>The Agency Evaluation report does not reflect the severity of the issues identified within this report nor does it reflect the issues identified during quarterly professional advisory meetings as follows:</p> <ul style="list-style-type: none"> <li>- 02/08/2007, 05/10/07, and 09/13/07 issues were identified in Plan of Care, Coordination of Care, Medication Management and OASIS documentation.</li> </ul> <p>None of these findings were reviewed during the Agency Evaluation.</p> <p>Failure of the agency's annual evaluation to accurately determine the extent that the program is appropriate, adequate, effective and efficient</p>	G 245	<p>The agency annual evaluation will be revised by August 31, 2008 to demonstrate that the program is appropriate, adequate, effective and efficient.</p> <p>By: President/CEO</p>	

*acceptance  
6/15/08  
for*

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G 245	Continued From page 59	G 245	The Director of Quality Improvement will revise the CQI program by August 31, 2008 to ensure that there is safe delivery of patient specific care including comprehensive concise documentation.	
G 250	484.52(b) CLINICAL RECORD REVIEW  At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.  This STANDARD is not met as evidenced by: Based on a review of the agency's Professional Advisory Committee meeting minutes from 02/08/07 to 02/08/08; Continuous Quality Improvement (CQI) Committee meeting minutes 01/08/07 to 11/29/07, Quality Improvement policy, and an interviews with the Director of Patient Services (DPS), evidence is lacking that the agency has an effective system in place to ensure the identification and resolution of quality of care issues.  Specifically, on 04/21/08 at 1:30 pm, an interview with the DPS was completed. The surveyor requested any and all quality improvement activities completed for 2007-2008. The DPS stated that the following activities were being completed: case management audits, start of care, resumption of care and recertification audits; focused reviews; and peer review audits. On 04/24/08, the DPS explained the purpose of each audit completed. The DPS stated that start of care, resumption of care and recertification audits are completed by the CQI committee, these audits are focused audits that evaluate only limited information.	G 250	Beginning June 30, 2008 the Director of Quality Improvement will ensure that the following audits are completed on an ongoing basis.  Quarterly supervisory home visits with audit will be conducted on clinicians by the Clinical Nurse Manager and Quality Care Coordinator.  Quarterly comprehensive audits will completed on 10% of active patients by the Clinical Nurse Managers and Quality Care Coordinator.  Focused audits will be conducted as necessary based on trends identified on comprehensive audits.  More frequent supervisory home visits with audit will be conducted on clinicians that are not meeting agency standards. Clinicians consistently not meeting agency standards will be placed on a corrective action plan.  The Director of Quality Improvement will ensure that audit result are analyzed for trends and results and recommendations are reported to CQI and PAC on a bi monthly and quarterly basis respectively.	

*acceptable Paula Williams*  
*6/18/08*

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1058 W GENESEE STREET  
SYRACUSE, NY 13204

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G 250	<p>Continued From page 80</p> <p>The DPS also provided the surveyor with a list of comprehensive audits completed for 2007, according to the list provided, only 44 comprehensive audits were completed for 2007. During an interview with the DPS on 04/24/08, she stated that the comprehensive audits were supposed to be completed by the Clinical Managers and the Quality Improvement manager. The DPS stated that there is no longer a Quality Improvement Manager therefore, very few comprehensive audits were completed. The comprehensive audit has not been an on-going part of the CQI process.</p> <p>During the interview on 04/24/08, the DPS stated that Tele-health audits were also completed as part of the Continuous Quality Improvement process. There is no evidence that the PAC committee received the results of tele-health findings for each quarter. Specifically, tele-health audits were completed for 11/07. The results were not reflected in the 02/08/08 PAC meeting minutes. The audits tools were reviewed and identified care coordination problems between the tele-health nurse and the skilled nurse.</p> <p>A review of the agency's policy labeled Continuous Quality Improvement Program was completed and failed to include a mechanism for correcting deficient practices identified throughout the Quality Improvement process.</p> <p>Failure to ensure that Quality Improvement Activities are comprehensive and reflect deficient practices of the agency has led to poor quality of care for the agency's patient population.</p>	G 250	<p>Start of Care focused audits will be performed on 10% of the admissions to the agency monthly. By CQI committee</p> <p><i>Per Amor Bango / PJW 6/18/08</i></p> <p><i>SOC audits include a review of Plans of Care and INA to ensure completeness.</i></p> <p>The Director of Quality Improvement will revise the CQI policy by August 31, 2008 to reflect a mechanism for correcting deficient practices identified including communication with the governing body. The revision will also include provisions to ensure that QI activities are comprehensive and address deficient practice.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER

GENTIVA HEALTH SERVICES LIVERPOOL

STREET ADDRESS, CITY, STATE, ZIP CODE

200 ELWOOD DAVIS ROAD  
LIVERPOOL, NY 13088

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G 000 INITIAL COMMENTS

This statement of deficiencies report is the result of complaint investigations NY00073917, NY00073918, NY00074675. The survey consisted of clinical record reviews for 3 patient's, interviews with the Administrator, acting Director of Clinical Management, Managers of Clinical Practice (MCP) and agency staff.

Additionally, policies and procedures, and the plans of correction were reviewed for the Condition Level Survey dated 04/15/09; the 45-day follow-up survey dated 05/28/09; and the second follow-up survey dated 06/07/09 during the complaint investigation.

Allegations identified in all three complaints were substantiated.

G 140 (\*) - indicates repeat deficiency  
484.14(d) SUPERVISING PHYSICIAN OR  
REGIS. NURSE

Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).

This person, or similarly qualified alternate, participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.

This STANDARD is not met as evidenced by:  
Based on a review of 3 clinical records, and  
interviews with the Administrator, acting Director

G 000

RECEIVED

OCT 22 2009

NYS Dept. of Health  
Central NY Regional Office

G140 484.14 (d) SUPERVISING  
PHYSICIAN OR REGISTERED NURSE

The administrator and Acting Director of Patient Services (ADPS) continue to conduct weekly MCP meetings and at these meetings specific duties to the MCP role are reviewed and discussed. Review of the MCP role as stated in the previous plans of corrections pursuant to the 5/28/09 follow up survey with regards to coordination and oversight of clinical field staff including but not limited to:

- 100% review of all SOC, ROC and recertification clinical records.
- Weekly case conferencing with each case manager clinician and proof of conferencing to be evident in clinical records.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Sharon DeSawero

Administrator

8/28/09

Deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

updated 9/28/09 Sharon DeSawero

updated 10/9/09 &amp; 10/22/09 Sharon DeSawero

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G 000	INITIAL COMMENTS  This statement of deficiencies report is the result of complaint investigations NY00073917, NY00073918, NY00074675. The survey consisted of clinical record reviews for 3 patient's, interviews with the Administrator, acting Director of Clinical Management, Managers of Clinical Practice (MCP) and agency staff.  Additionally, policies and procedures, and the plans of correction were reviewed for the Condition Level Survey dated 04/15/09; the 45-day follow-up survey dated 05/28/09; and the second follow-up survey dated 06/07/09 during the complaint investigation.  Allegations identified in all three complaints were substantiated.	G 000			
G 140	(*) - indicates repeat deficiency 484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE  Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).  This person, or similarly qualified alternate, participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.  This STANDARD is not met as evidenced by: Based on a review of 3 clinical records, and interviews with the Administrator, acting Director	G 140 <i>acceptable 10/28/09</i> <i>Parolee Williams RN</i>	<b>G140 484.14 (d) SUPERVISING PHYSICIAN OR REGISTERED NURSE</b>  The administrator and Acting Director of Patient Services (ADPS) continue to conduct weekly MCP meetings and at these meetings specific duties to the MCP role are reviewed and discussed. Review of the MCP role as stated in the previous plans of corrections pursuant to the 5/28/09 follow up survey with regards to coordination and oversight of clinical field staff including but not limited to: -100% review of all SOC, ROC and recertification clinical records. -Weekly case conferencing with each case manager clinician and proof of conferencing to be evident in clinical records.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Sharon DeSavero*

TITLE

*Administrator*

(X6) DATE

*8/28/09*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

*updated 9/28/09 Sharon DeSavero*



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G 140	<p>Continued From page 1</p> <p>of Clinical Management (DCM), Manager of Clinical Practice (MCP), and agency staff, evidence is lacking in 3 records that the following supervisory responsibilities are being performed:</p> <ul style="list-style-type: none"> <li>o Failure to conduct case conferences within weekly intervals as outlined in the plans of corrective action to the 04/15/09, 05/28/09 and 06/07/09 surveys. The plans of corrective action state that case conferences will be conducted at admission, resumption of care, recertification and weekly.</li> <li>o Failure to ensure that on-call staff have adequate information regarding patient condition to ensure patient needs are met.</li> <li>o Failure to ensure that plans of care are complete for all diagnoses medications and treatments. See G159</li> <li>o Failure to ensure that nursing assessments and reassessments are complete and accurately reflect the patient's status and continuing needs. See G171, G172</li> </ul> <p>Examples:</p> <p>1. Lack of Case Conferencing:</p> <p>Patient #1 was admitted to the agency on 06/18/09 with prostatic disorder requiring an indwelling foley catheter and insulin dependent diabetes. The plan of care included skilled nursing and occupational therapy services. There is no evidence of adequate case conferences as follows:</p> <p>- case conference was completed on 06/18/09,</p>	G 140	<p>-Documentation of coordination and follow-up when informed of change in patient condition, including physician notification.</p> <p>Weekly case conferencing is being completed in each branch with each MCP by team, on scheduled dates and times. In addition care coordination is also documented (PT/PTA; LPN/RN) on the visit notes.</p> <p>The clinical records not evident of case conferencing on multidisciplinary forms included conferencing in clinical notes, and for those conferencing taking place less frequently than weekly, the staff currently employed have been counseled regarding breach of process. Noted if process breach continues, written counseling and further corrective action will be followed.</p> <p>The On call process was reviewed with the surveyors at survey, including copies of on call logs and coverage schedule for nurse and MCP coverage, as well as the process summarized and sent to the Department of</p>		<p>9/28/09</p> <p>acceptable Paula Williams</p>

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G 140	<p>Continued From page 2</p> <p>with the MCP and the skilled nurse. There is no evidence that the MCP identified an incomplete plan of care and initial nursing assessment as outlined in this report.</p> <ul style="list-style-type: none"> <li>- case conferences were not completed weekly and when the case conference was completed, the nurse case manager was not included. Specifically, a multidisciplinary case conference was conducted with the occupational therapist on 05/30/09.</li> </ul> <p>Patient # 2 was admitted to the agency on 05/30/09, with a diagnosis of congestive heart failure and a non-healing surgical wound to the left foot. The plan of care includes daily skilled nursing for wound care, physical therapy, nutrition, and medical social work services. There is no evidence that adequate case conferences as follows:</p> <ul style="list-style-type: none"> <li>- initial case conference form was included in the clinical record however, was not signed or dated by the MCP.</li> <li>- weekly case conferences were not completed, the first case conference in the record was 4 weeks after admission and was not multidisciplinary.</li> <li>- 06/23/09 case conference was completed with the case manager. There was no evidence a review of patient care and coordination as outlined in the policy.</li> </ul> <p>Patient #3 was admitted to the agency on 04/22/09 following abdominal surgery which required an ileostomy. The initial nursing assessment included a patient medical history of</p>	G 140	<p>Health on 7/21/09. The MCP has a laptop with access to patient information: a master patient list with patient demographic information, diagnosis, physician, emergency disaster code, and emergency contact information. If a patient visit is necessary the on-call visit nurse can call MCP for further information if needed since MCP can supply additional patient information. The staffs also have a copy of the plan of care and any pink copies of notes in the patient's home upon arrival.</p> <p>Professional staff has been re-instructed at team meetings of the importance of continuing compliance with weekly case conferencing on all patients after SOC, ROC and recertification, for cases that are multidisciplinary and for patients with a change in condition. They have also been re-instructed on notifying MD for patient change in condition, or hospitalization needs, and to communicate any on call issues to the MCP first thing next working day, or if urgent and cannot wait to call immediately.</p> <p>The MCP's and QA nurses will continue to audit clinical records (10%) per month both active and discharged and evaluate case conferencing and on-call compliance. Staff not following protocol will have corrective action process initiated.</p> <p>Responsible parties: Administrator, ADPS, MCP, and QA nurse.</p>

09/09 Addendum:

The on-call process has been updated as follows: R  
Our CTC (scheduler) takes the call from the answering service; if not scheduling issue contacts the MCP who contacts the on-call RN as needed. SN -

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G 140	<p>Continued From page 2</p> <p>with the MCP and the skilled nurse. There is no evidence that the MCP identified an incomplete plan of care and initial nursing assessment as outlined in this report.</p> <ul style="list-style-type: none"> <li>- case conferences were not completed weekly and when the case conference was completed, the nurse case manager was not included. Specifically, a multidisciplinary case conference was conducted with the occupational therapist on 06/30/09.</li> </ul> <p>Patient # 2 was admitted to the agency on 05/30/09, with a diagnosis of congestive heart failure and a non-healing surgical wound to the left foot. The plan of care includes daily skilled nursing for wound care, physical therapy, nutrition, and medical social work services. There is no evidence that adequate case conferences as follows:</p> <ul style="list-style-type: none"> <li>- initial case conference form was included in the clinical record however, was not signed or dated by the MCP.</li> <li>- weekly case conferences were not completed, the first case conference in the record was 4 weeks after admission and was not multidisciplinary.</li> <li>- 06/23/09 case conference was completed with the case manager. There was no evidence a review of patient care and coordination as outlined in the policy.</li> </ul> <p>Patient #3 was admitted to the agency on 04/22/09 following abdominal surgery which required an ileostomy. The initial nursing assessment included a patient medical history of</p>	G 140	<p>Health on 7/21/09. The MCP has a laptop with access to patient information: a master patient list with patient demographic information, diagnosis, physician, emergency disaster code, and emergency contact information. If a patient visit is necessary the on-call visit nurse can call MCP for further information if needed since MCP can supply additional, patient information. The staffs also have a copy of the plan of care and any pink copies of notes in the patient's home upon arrival.</p> <p>Professional staff has been re-instructed at team meetings of the importance of continuing compliance with weekly case conferencing on all patients after SOC, ROC and recertification, for cases that are multidisciplinary and for patients with a change in condition. They have also been re-instructed on notifying MD for patient change in condition, or hospitalization needs, and to communicate any on call issues to the MCP first thing next working day, or if urgent and cannot wait to call immediately.</p> <p>The MCP's and QA nurses will continue to audit clinical records (10%) per month both active and discharged and evaluate case conferencing and on-call compliance. Staff not following protocol will have corrective action process initiated.</p> <p>Responsible parties: Administrator, ADPS, MCP, and QA nurse.</p>	9/28/09	

Not acceptable see addendum

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G 140	<p>Continued From page 3</p> <p>scleroderma, rheumatoid arthritis, scleroderma and a chronic foot wound. There is no evidence that adequate case conferences were conducted as follows:</p> <ul style="list-style-type: none"> <li>- weekly case conferences were not completed. The first case conference was completed on 05/21/09, one month after admission.</li> <li>- 05/21/09 - There was no evidence of a review of patient care and coordination documented during the case conference.</li> <li>- 05/31/09 - resumption of care case conference was completed. There was no evidence that the clinical record was reviewed by the MCP to determine adequate patient care and coordination. The next case conference was 22 days later on 06/23/09.</li> <li>- 06/23/09 - case conference with the skilled nurse and the MCP. There was no review of the clinical record or discussion of the patient's frequent need to access the on-call system for leaking ileostomy appliance.</li> </ul> <p>The lack of completed case conferences was discussed with the acting DCM, MCP and Administrator on 05/08/09. The Administrator states that the agency is recruiting for new MCPs and are sending the acting DCM to assist in the case conferencing and supervisory process.</p> <p>2. Failure to ensure that on-call staff have adequate information regarding patient condition to ensure patient needs are met.</p> <p>Based on a review of on-call logs, agency policy 5-1 Office Organization - On-Call, and interviews</p>	G 140			

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G 140	<p>Continued From page 4</p> <p>with the acting Director of Clinical Management (DCM), Manager of Clinical Practice (MCP) and agency on-call personnel, there is no evidence that on-call staff have sufficient information to adequately triage patient phone calls. Specifically, 3 registered nurses (RN) who have on-call responsibility were interviewed between 07/07/09 to 08/20/09. The surveyor asked each of the three RNs what information they have with them when they are on call. Each nurse stated that the only information that they have is the patient roster which includes the patient's name, demographics, primary diagnosis and physician name and phone number.</p> <p>Examples:</p> <p>Patient # 1 was admitted to the agency on 06/18/09 with a primary diagnosis of fitting urinary devices, prostatic disorders, type II diabetes, and chronic obstructive pulmonary disease.</p> <p>This patient was identified in the on-call log as requiring nursing consultation. A review of the clinical record and interview with the on-call nurse identified the following on-call issue.</p> <p>Specifically, on 06/21/09 08:30 pm, the private aide contacted the on-call nurse regarding blood in the patient's catheter and that the patient was on coumadin. The skilled nurse failed to visit the patient to ascertain the seriousness of the bleeding and failed to consult the physician prior to sending the patient to the emergency department.</p> <p>An interview was conducted by the surveyor with the on call nurse on 08/14/09 to determine why an assessment visit was not conducted? The</p>	G 140			

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G 140	<p>Continued From page 5</p> <p>on-call nurse stated "I had no information about this patient when I received the call from the aide stating that the patient had blood in his catheter and was taking coumadin" The surveyor asked for an explanation of the information she did have for this patient. The nurse stated "I only had the patient roster which has the patient's demographics, diagnosis and physician". The surveyor asked the on-call nurse if she contacted the physician to discuss the patient's condition prior to sending the patient to the emergency room. The nurse stated that she did not contact the physician.</p> <p>The surveyor reviewed the plan of care dated 06/18/09 which contained orders to flush the patient's catheter as needed. The surveyor asked the on-call nurse if she was aware of this order she stated "no, I only had the patient roster".</p> <p>Patient # 3 was admitted to the agency on 04/22/09 following abdominal surgery requiring an ileostomy. The patient has a long standing history of scleroderma, and severe rheumatoid arthritis making it impossible to cut the ileostomy appliance and make fit. The plans of care dated 04/22/09 to 06/20/09 and 06/21/09 to 08/19/09 state that skilled nursing visits are needed to change the patient's ileostomy 2 times a week and 4 as needed visits for problems with the ileostomy bag.</p> <p>On 06/29/09, the patient accessed the agency's on call system at 4:30 am because her colostomy bag had broken and was leaking. The on-call nurse documented that she told the patient that she would be out to see her at 7:30 am and that she should just wrap it with a towel or tape it until</p>	G 140		

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G 140

Continued From page 6  
she could be there at 7:30 am. The on-call nurse did not visit the patient. On 07/06/09, the surveyor interviewed the on-call nurse and asked her to explain why she did not go out to see the patient? The on-call nurse stated "I thought that her colostomy would be okay until morning and that she could just cover it with a wash cloth" The surveyor asked the on-call nurse if she was aware the the patient had an ileostomy not a colostomy. The surveyor also asked if the on-call nurse was aware that the patient had severe rheumatoid arthritis which made it very difficult for her to care for the ileostomy. The on-call nurse stated "I did not know that the patient had rheumatoid arthritis. The only information that I had was the patient roster".

This information was discussed with the Administrator on 07/09/09. The Administrator stated that the on-call nurses can contact the MCP who has computer access to the patient's plan of care with all diagnoses.

(\*) - repeat deficiency

G 159

484.18(a) PLAN OF CARE

The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.

This STANDARD is not met as evidenced by:

G 140

G 159

**G159 484.18 (a) PLAN OF CARE**

The process of the plan of care developed by the evaluating clinician and reviewed and processed by the MCP has been reviewed with the MCP in the Auburn branch. Importance of attention to detail discussed and errors identified were immediately clarified by the MCP and case manager RN and the patient physician.

*10/20/09 acceptable*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337255	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 08/20/2009
NAME OF PROVIDER OR SUPPLIER  GENTIVA HEALTH SERVICES LIVERPOOL			STREET ADDRESS, CITY, STATE, ZIP CODE 200 ELWOOD DAVIS ROAD LIVERPOOL, NY 13088		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G.159	<p>Continued From page 7</p> <p>Based on a review of 3 clinical records interviews with the Administrator, acting Director of Clinical Management (DCM), Manager of Clinical Practice (MCP) and agency staff there is no evidence in 2 records that the plan of care is of sufficient scope to meet the patient's needs. Patient # 1 and 2.</p> <p>Failure to ensure that the plan of care is of sufficient scope has the potential for unmet patient needs.</p> <p>1. Patient #1 was admitted to the agency on 06/18/09 with prostatic disorder requiring an indwelling foley catheter and insulin dependent diabetes. The plan of care failed to include the following:</p> <ul style="list-style-type: none"> <li>- complete and accurate medication orders: Novolog flex pen sliding scale is ordered, however, there is no frequency or dose for administration.</li> <li>- plan to monitor blood sugars including the frequency for testing</li> <li>- specifics related to catheter care.</li> <li>- parameters for irrigating the foley catheter as needed</li> <li>- plan to assess and instruct in bleeding precautions related to the use of Coumadin a blood thinner.</li> </ul> <p>This record was reviewed with the MCP and acting DCM on 07/08/09, and the Administrator on 07/09/09. The MCP was suprised that she did not identify that the plan of care was incomplete.</p>	G 159	<p>In review of the detail in the statement of deficiencies for patient #1, foley catheter care orders and irrigation orders for foley catheter are present on the plan of care, (foley was to be irrigated if it became plugged and/or not draining urine) The safety precautions of anticoagulant therapy for patient on Coumadin were listed. MCP self identified information not included in the plan of care and immediately worked with the case manager to verify and obtain more clear order for insulin sliding scale. Patient and/family educated on the correct dosages. Patient #2, omission of information on plan of treatment corrected once identified.</p> <p>100% of plans of treatment will be reviewed by MCP/QA nurse to evaluate complete and accurate information reflected in plan of treatment that portrays assessment completed by evaluating clinician.</p> <p>Ongoing clinical record audits of 10% of all records by MCP/QA nurses each quarter, any area identified as not meeting threshold in areas audited, or not showing improvement will have action plan developed to achieve positive results by the PI committee for improvement.</p> <p>Responsible parties: Administrator, ADPS, MCP, and QA Nurse.</p>	<p>But not specific to foley irrigation verified 10/19/09 SD It is no longer on service SD</p>	

10/19/09 acceptable foley irrigation



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G.159	<p>Continued From page 7</p> <p>Based on a review of 3 clinical records interviews with the Administrator, acting Director of Clinical Management (DCM), Manager of Clinical Practice (MCP) and agency staff there is no evidence in 2 records that the plan of care is of sufficient scope to meet the patient's needs. Patient # 1 and 2.</p> <p>Failure to ensure that the plan of care is of sufficient scope has the potential for unmet patient needs.</p> <p>1. Patient #1 was admitted to the agency on 06/18/09 with prostatic disorder requiring an indwelling foley catheter and insulin dependent diabetes. The plan of care failed to include the following:</p> <ul style="list-style-type: none"> <li>- complete and accurate medication orders: Novolog flex pen sliding scale is ordered, however, there is no frequency or dose for administration.</li> <li>- plan to monitor blood sugars including the frequency for testing</li> <li>- specifics related to catheter care.</li> <li>- parameters for irrigating the foley catheter as needed</li> <li>- plan to assess and instruct in bleeding precautions related to the use of Coumadin a blood thinner.</li> </ul> <p>This record was reviewed with the MCP and acting DCM on 07/08/09, and the Administrator on 07/09/09. The MCP was suprised that she did not identify that the plan of care was incomplete.</p>	G.159	<p>In review of the detail in the statement of deficiencies for patient #1, foley catheter care orders and irrigation orders for foley catheter are present on the plan of care, foley was to be irrigated if it became plugged and/or not draining urine. The safety precautions of anticoagulant therapy for patient on Coumadin were listed. MCP self identified information not included in the plan of care and immediately worked with the case manager to verify and obtain more clear order for insulin sliding scale. Patient and/family educated on the correct dosages. Patient #2, omission of information on plan of treatment corrected once identified.</p> <p>100% of plans of treatment will be reviewed by MCP/QA nurse to evaluate complete and accurate information reflected in plan of treatment that portrays assessment completed by evaluating clinician.</p> <p>Ongoing clinical record audits of 10% of all records by MCP/QA nurses each quarter, any area identified as not meeting threshold in areas audited, or not showing improvement will have action plan developed to achieve positive results by the PI committee for improvement.</p> <p>Responsible parties: Administrator, ADPS, MCP, and QA Nurse.</p>		

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G 159	Continued From page 8  2. Patient #2 was admitted to the agency on 05/30/09 with a primary diagnosis of congestive heart failure and secondary diagnoses of infection of a post operative toe amputation wound. The plan of care failed to include the following:  - plan for the skilled nurse to pre-pour medication weekly as documented in the initial nursing assessment dated 05/30/09.  This record was reviewed with the Administrator on 08/20/09. No further information was provided.	G 159			
G 171	(*) - Repeat Deficiency 484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse makes the initial evaluation visit.  This STANDARD is not met as evidenced by: Based on a review of 3 clinical records and interviews with the Administrator, acting Director of Clinical Management (DCM) and agency staff, there is no evidence in 2 records that the initial nursing assessment is complete and accurately reflects the patient's needs. Patients #1, 2.  Failure to adequately assess patients needs has the potential for unmet patient needs.  1. Patient # 1 was admitted to the agency on 06/18/09 with a primary diagnosis of fitting urinary device and secondary diagnoses of prostatic disorders, type II diabetes, and chronic obstructive pulmonary disease. The initial	G 171	G171 484.30 (a) DUTIES OF THE REGISTERED NURSE  The MCP's conduct weekly team meetings where at all meetings the skilled professional staff were educated on documentation in May and June 2009 and will be re-educated on the importance of documentation of specific assessment findings and following the plan of care as created. This mandatory review will be completed by 9/15/09 in all branches.		

10/22/09 acceptable Paul G. [signature]

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GENTIVA HEALTH SERVICES LIVERPOOL

STREET ADDRESS, CITY, STATE, ZIP CODE

200 ELWOOD DAVIS ROAD  
LIVERPOOL, NY 13088

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G 171	<p>Continued From page 9</p> <p>nursing assessment dated 06/18/09 failed to include the following:</p> <ul style="list-style-type: none"> <li>- an assessment of how the patient's personal needs will be met. Specifically, the ADL/IADL portion of the initial nursing assessment document states that the patient depends on another person for all personal care need. There is no documentation of who will assist the patient with these needs.</li> <li>- date foley catheter was previously changed or due to be changed</li> <li>- ability to administer Novolog flex pen sliding scale insulin</li> <li>- patient's ability to monitor blood sugars, specifically, the skilled nurse documented that the patient did not have a glucometer</li> <li>- no measurement/description of the patient's left leg wound described as a "left leg abrasion".</li> </ul> <p>This record was reviewed with the MCP and acting DCM on 07/08/09, and the Administrator on 07/09/09. No further information was provided.</p> <p>2. Patient #2 was admitted to the agency on 05/30/09 with a primary diagnosis of congestive heart failure and secondary diagnoses of infection of a post operative toe amputation wound. The initial nursing assessment failed to include the following:</p> <ul style="list-style-type: none"> <li>- measurement of the non-healing surgical wound to the left foot which is described as tan/yellow purulent drainage with a mild odor.</li> </ul>	G 171	<p>In review of the statement of deficiencies, all clinicians identified as not achieving optimal assessment and documentation according to the plan of care and orders on issues identified on patient #1 and patient #2 have been counseled regarding the missing information as well as its effect on the plan of treatment.</p> <p>To prevent the recurrence of these issues, QA nurses and MCP's will continue to audit 10% of all clinical records per quarter for following the plan of care as assessed. The clinicians not following the plan of care will begin a corrective action process and if necessary be put on an action plan to improve documentation and follow up. This will be enforced by the team MCP.</p> <p>Responsible parties: Administrator, ADPS, MCP, and QA Nurse.</p> <p><i>*to ensure initial assessments are correct 10/22/09 sm</i></p>	8010/22/09

*acceptable 10/22/09*

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NYS Dep  
Central NY

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G 171	<p>Continued From page 9</p> <p>nursing assessment dated 06/18/09 failed to include the following:</p> <ul style="list-style-type: none"> <li>- an assessment of how the patient's personal needs will be met. Specifically, the ADL/IADL portion of the initial nursing assessment document states that the patient depends on another person for all personal care need. There is no documentation of who will assist the patient with these needs.</li> <li>- date foley catheter was previously changed or due to be changed</li> <li>- ability to administer Novolog flex pen sliding scale insulin</li> <li>- patient's ability to monitor blood sugars, specifically, the skilled nurse documented that the patient did not have a glucometer</li> <li>- no measurement/description of the patient's left leg wound described as a "left leg abrasion".</li> </ul> <p>This record was reviewed with the MCP and acting DCM on 07/08/09, and the Administrator on 07/09/09. No further information was provided.</p> <p>2. Patient #2 was admitted to the agency on 05/30/09 with a primary diagnosis of congestive heart failure and secondary diagnoses of infection of a post operative toe amputation wound. The initial nursing assessment failed to include the following:</p> <ul style="list-style-type: none"> <li>- measurement of the non-healing surgical wound to the left foot which is described as tan/yellow purulent drainage with a mild order.</li> </ul>	G 171	<p>In review of the statement of deficiencies, all clinicians identified as not achieving optimal assessment and documentation according to the plan of care and orders on issues identified on patient #1 and patient #2 have been counseled regarding the missing information as well as its effect on the plan of treatment.</p> <p>To prevent the recurrence of these issues, QA nurses and MCP's will continue to audit 10% of all clinical records per quarter for following the plan of care as assessed. The clinicians not following the plan of care will begin a corrective action process and if necessary be put on an action plan to improve documentation and follow up. This will be enforced by the team MCP.</p> <p>Responsible parties: Administrator, ADPS, MCP, and QA Nurse.</p>		

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G 171	Continued From page 10	G 171			
G 172	<p>This record was reviewed with the Administrator on 08/20/09. No further information was provided.</p> <p>(*) - Repeat Deficiency 484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse regularly re-evaluates the patients nursing needs.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 3 clinical records and interviews with the Administrator, acting Director of Clinical Management (DCM) and agency staff, there is no evidence in 3 records (100%) that the skilled nursing reassessments are complete and accurately reflect the patient's current status. Patients #1-3</p> <p>Failure to provide complete and accurate skilled nursing reassessments has the potential for unmet patient needs.</p> <p>1. Patient #2 was admitted to the agency on 05/30/09 with a primary diagnosis of atrial fibrillation and secondary diagnoses of congestive heart failure, toe amputation with subsequent post-operative infection and type II diabetes. The patient lives alone and the plan of care states that the skilled nursing visits daily. The skilled nurse failed to provide adequate assessment of the following:</p> <p>- medication management Specifically, during the initial nursing assessment the skilled nurse documented "patient unaware of meds"</p>	G 172	<p><b>G172 484.30 (a) DUTIES OF THE REGISTERED NURSE</b></p> <p>The MCP's conduct weekly team meetings where at all meetings the skilled professional staff were educated in May and June 2009 and will be re-educated on the importance of documentation of specific assessment findings and following the plan of care as created. This mandatory review will be completed by 9/15/09 in all branches.</p> <p>In review of the statement of deficiencies, all clinicians identified as not achieving optimal assessment and documentation according to the plan of care and orders on issues identified on patient #1 #2, and patient #3 have been counseled regarding the missing information as well as its effect on the plan of treatment.</p> <p>To prevent the recurrence of these issues, QA nurses and MCP's will continue to audit 10% of all clinical records per quarter for following the plan of care as assessed. The clinicians not following the plan of care will begin a corrective action process and if necessary be put on an action plan to improve documentation and follow up. This will be enforced by the team MCP.</p> <p>Responsible parties: Administrator, ADPS, MCP, and QA Nurse.</p>	<p>10/22/09 acceptable</p> <p>10/22/09</p>	

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for ensuring reassessments  
are documented completely  
and accurately 10/22/09

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G 171	Continued From page 10	G 171			
G 172	<p>This record was reviewed with the Administrator on 08/20/09. No further information was provided.</p> <p>(*) - Repeat Deficiency</p> <p><b>484.30(a) DUTIES OF THE REGISTERED NURSE</b></p> <p>The registered nurse regularly re-evaluates the patients nursing needs.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 3 clinical records and interviews with the Administrator, acting Director of Clinical Management (DCM) and agency staff, there is no evidence in 3 records (100%) that the skilled nursing reassessments are complete and accurately reflect the patient's current status. Patients #1-3</p> <p>Failure to provide complete and accurate skilled nursing reassessments has the potential for unmet patient needs.</p> <p>1. Patient #2 was admitted to the agency on 05/30/09 with a primary diagnosis of atrial fibrillation and secondary diagnoses of congestive heart failure, toe amputation with subsequent post-operative infection and type II diabetes. The patient lives alone and the plan of care states that the skilled nursing visits daily. The skilled nurse failed to provide adequate assessment of the following:</p> <p>- medication management Specifically, during the initial nursing assessment the skilled nurse documented "patient unaware of meds"</p>	G 172	<p><b>G172 484.30 (a) DUTIES OF THE REGISTERED NURSE</b></p> <p>The MCP's conduct weekly team meetings where at all meetings the skilled professional staff were educated in May and June 2009 and will be re-educated on the importance of documentation of specific assessment findings and following the plan of care as created. This mandatory review will be completed by 9/15/09 in all branches.</p> <p>In review of the statement of deficiencies, all clinicians identified as not achieving optimal assessment and documentation according to the plan of care and orders on issues identified on patient #1 #2, and patient #3 have been counseled regarding the missing information as well as its effect on the plan of treatment.</p> <p>To prevent the recurrence of these issues, QA nurses and MCP's will continue to audit 10% of all clinical records per quarter for following the plan of care as assessed. The clinicians not following the plan of care will begin a corrective action process and if necessary be put on an action plan to improve documentation and follow up. This will be enforced by the team MCP.</p> <p>Responsible parties: Administrator, ADPS, MCP, and QA Nurse.</p>		

*add to say*

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G 172	<p>Continued From page 11</p> <p>(medications) taking, regarding : name, frequency, action" The skilled nurse set up medication in pill organizers, however, the patient was missing the following medications:</p> <ul style="list-style-type: none"> <li>- Coumadin, Coreg, Asprin, Lisinopril.</li> </ul> <p>There was no skilled nurse visit until 06/03/09. During the 06/03/09 visit, the skilled nurse failed to determine if the patient obtained the missing medications identified on 05/30/09.</p> <ul style="list-style-type: none"> <li>- wound assessments: on 05/30/09, the skilled nurse documented that the patient had a left 2nd and 3rd toe wound as a result of an amputation. There was no measurement of this wound during until 12 days later on 06/12/09. On 06/12/09, the skilled nurse documented that the patient's wound was triangular shape "base approximately 3 cm and sides 4 cm each." There was no actual wound measurement until 06/26/09: 2 cm x 3 cm x 2 cm.</li> <li>- weight: The initial nursing assessment stated that the patient's actual weight was 170 pounds, the plan of care states that the patient should be weighed daily and a 5 pound weight gain reported to the physician. During skilled nursing visits completed from 06/03/09 to 06/26/09 there was no weight assessed.</li> <li>- blood sugar monitoring. There is no evidence that the skilled nurse consistently monitored the patient's blood sugar readings during skilled nursing visits conducted on 06/03, 06, 09, 16, 18, 22, 25, 28.</li> </ul> <p>This record was reviewed with the Administrator on 08/20/09. No further information was</p>	G 172			

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G 172	<p>Continued From page 12 provided.</p> <p>2. Patient # 1 was admitted to the agency on 06/18/09 with a primary diagnosis of fitting urinary devices, prostatic disorders, type II diabetes, and chronic obstructive pulmonary disease. There is no evidence that the skilled nurse adequately assessed the following:</p> <ul style="list-style-type: none"> <li>- patient's knowledge and use of glucometer. During the initial nursing assessment on 06/18/09 and 06/19/09, the skilled nurse documented that the patient did not have a glucometer, therefore, no assessment or teaching of glucometer use was completed. On 06/23/09, the skilled nurse documented that the patient "performs own glucose monitoring" and had a blood sugar of 298. There was no observation of the patient performing the blood sugar testing; no documentation of whether the blood sugar was fasting or random; and no assessment of the patient's use of Novalog sliding scale insulin pen.</li> </ul> <p>Additionally, blood sugars documented during skilled nursing visits on 06/30/09, 07/02/09, and 07/06/09 were 169 each visit. There was no assessment of the time the blood sugars were obtained; if they were fasting or random, and no clarification with the physician to determine the dosage and frequency for the administration of Novolog flex pen for sliding scale insulin.</p> <p>The skilled nurse failed to provide adequate assessment of the patient's condition prior to sending the patient to the emergency room.</p> <p>Specifically, on 06/21/09 08:30 pm, the private aide contacted the on-call nurse regarding blood in his catheter and that the patient was on</p>	G 172			



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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 172	<p>Continued From page 13</p> <p>coumadin. The skilled nurse failed to visit the patient to ascertain the seriousness of the bleeding and failed to consult the physician prior to sending the patient to the emergency department.</p> <p>An interview was conducted by the surveyor with the on call nurse on 08/14/09 to determine why an assessment visit was not conducted? The on-call nurse stated "I had no information about this patient when I received the call from the aide stating that the patient had blood in his catheter and was taking coumadin" The surveyor asked for an explanation of the information she did have for this patient. The nurse stated "I only had the patient roster which has the patient's demographics, diagnosis and physician". The surveyor asked the on-call nurse if she contacted the physician to discuss the patient's condition prior to sending the patient to the emergency room. The nurse stated that she did not contact the physician.</p> <p>The surveyor reviewed the plan of care dated 06/18/09 which contained orders to flush the patient's catheter as needed. The surveyor asked the on-call nurse if she was aware of this order she stated "no, I only had the patient roster".</p> <p>Additionally, there was no skilled nursing follow-up until two days later, on 06/23/09. During that visit the skilled nurse documented that the patient did not go to the emergency room until 06/22/09.</p> <p>This record was reviewed with the MCP and acting DCM on 07/08/09, and the Administrator on 07/09/09. No further information was</p>	G 172			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/20/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>337255</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/20/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>GENTIVA HEALTH SERVICES LIVERPOOL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 ELWOOD DAVIS ROAD</b> <b>LIVERPOOL, NY 13088</b>		
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G 172	<p>Continued From page 14 provided.</p> <p>3. Patient #3 was admitted to the agency on 04/22/09 following abdominal surgery which required an ileostomy. The plan of care states skilled nursing visits twice weekly. The initial nursing assessment included a history of scleroderma, rheumatoid arthritis, scleroderma and hypotension and a chronic ulcer of the foot.</p> <p>The skilled nurse failed to adequately assess the patient's condition on 05/26/09. Specifically, the skilled nurse visited the patient and documented that the patient had black liquid stool in her ileostomy bag; the patient's weight had decreased from 91 pounds on 05/22/09 to 86 pounds representing a 5 pound weight loss and failed to assess the condition of the left toe wound. There was no evidence that the skilled nurse notified her supervisor or the physician that black liquid stool and a 5 pound weight loss was a change in the patient's condition.</p> <p>On 06/02/09, the skilled nurse documented that the patient was transferred to the hospital on 05/27/09 and admitted for treatment of cellulitis of the left leg. On 05/31/09, the care was resumed and the skilled nurse documented the following 3 wounds:</p> <p>Wound #1 - left medial foot - 1.7 cm x 1.2 cm Wound #2 - right dorsum - 0.5 cm x 0.5 cm pinpoint opening Wound #3 - callus right dorsum 0.5 cm x 0.5 cm</p> <p>Wounds #2 and 3 were not observed or measured from 06/02/09 to 07/06/09.</p> <p>This record was reviewed with Administrator on</p>	G 172			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/20/2009  
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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER

**GENTIVA HEALTH SERVICES LIVERPOOL**

STREET ADDRESS, CITY, STATE, ZIP CODE

**200 ELWOOD DAVIS ROAD  
LIVERPOOL, NY 13088**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 172	Continued From page 15 08/20/09. No further information was provided.  (* ) - Repeat Deficiency	G 172		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>337255</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/20/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>GENTIVA HEALTH SERVICES LIVERPOOL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 ELWOOD DAVIS ROAD LIVERPOOL, NY 13088</b>		
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J 236	<p>763.2(a)(9) Patients' Rights</p> <p>763.2 Patients' Rights.</p> <p>(a) The governing authority shall develop and implement written policies and procedures regarding the rights of the patient. These rights, policies and procedures shall afford each patient the right to:</p> <p>.....</p> <p>(9) be treated with consideration, respect and full recognition of his or her dignity and individuality;</p> <p>This Regulation is not met as evidenced by: Based on clinical record reviews and interviews with the Administrator, acting Director of Clinical Management (DCM) and Manager of Clinical Practice (MCP), there is evidence that one of three patients reviewed was not treated with dignity and respect. Patient # 3</p> <p>Failure to treat patient's with dignity and respect has the potential for unmet patient needs and an increase in anxiety when additional patient care is needed and not provided.</p> <p>Specifically:</p> <p>Patient # 3 was admitted to the agency on 04/22/09 following abdominal surgery requiring an ileostomy. The patient has a long standing history of scleroderma, and severe rheumatoid arthritis making it impossible to cut the ileostomy appliance and make fit. The plans of care dated</p>	<p>J 236</p> <p><i>10/22/09 acceptable Paula Williams RN</i></p>	<p><b>J236 763.2(a) (9) PATIENTS' RIGHTS</b></p> <p>The MCP's conduct weekly team meetings where at all meetings the skilled professional staff were re-educated on the complaint process and importance of documentation of a complaint or potential complaint. This mandatory review was completed by 8/20/09 in all branches, with all disciplines. A review of the patient's bill of rights will be conducted and completed with all staff, in all branches by 9/30/09.</p> <p>The clinician involved in the issues identified in statement of deficiencies patient #3 was counseled regarding her response to the patient call during the night on separate occasions in June 2009. This nurse was also put on an action plan by her MCP to assist in improving areas identified as not meeting expectations. The MCP is monitoring her progress.</p> <p>In an effort to prevent this from recurring, the MCP's will review the complaint process and on call process monthly at team meetings for optimal understanding by all clinicians, and to educate new staff as they join the teams.</p>	<p><i>9/30/09</i></p>

Office of Health Systems Management / Office of Long Term Care

*Sharon DeSavero*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DATE FORM

Version 09/12/08

0809

OKPS11

TITLE

*Administrator*

(X6) DATE

*8/28/09*

If continuation sheet 1 of 6

*updated 9/28/09 Sharon DeSavero*

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>337255</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/20/2009</b>
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J 236	<p>Continued From page 1</p> <p>04/22/09 to 06/20/09 and 06/21/09 to 08/19/09 state that skilled nursing visits are needed to change the patient's ileostomy 2 times a week and 4 as needed visits for problems with the ileostomy bag.</p> <p>On 06/29/09, the patient accessed the agency's on call system at 4:30 am because her colostomy bag had broken and was leaking. The on call nurse documented that she told the patient that she would be out to see her at 7:30 am and that she should just wrap it with a towel or tape it until she could be there at 7:30 am. The patient stated that if it's going to wait until then "I'll just call my regular nurse." The on-call nurse did not visit the patient and the patient called her case manager directly at 7 am.</p> <p>When the case manager visited the patient at 8:00 am on 06/29/09, the patient informed her that she was very upset that the on-call nurse did not visit and that the patient had to put a washcloth over the stoma.</p> <p>The case manager documented in the clinical record that she informed the MCP about the patient's concerns, however, neither the MCP or the case manager asked the patient if she wanted to voice a complaint.</p> <p>The surveyor interviewed the patient on 07/02/09, the patient stated that she was very upset with the on-call nurse not only because she did not visit the patient but also because she said "it's the middle of the night! Can't you just put a towel on it and wait until morning?" The patient stated that she did not feel that the nurse realized that she was severely debilitated from rheumatoid arthritis.</p> <p>On 07/06/09, the patient encountered another issue with the on-call system and felt that she</p>	J 236	<p>MCP's and QA nurses will continue to audit 10% of clinical records to assess for compliance with complaint process management. Clinicians not following protocol will have a corrective action counseling process begun. Those with consistent breach in process will be put on an action plan for improvement by the MCP.</p> <p>Responsible parties: Administrator, ADPS, MCP, and QA Nurse.</p>		

New York State Department of Health

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J 236	<p>Continued From page 2 was treated poorly.</p> <p>On 07/06/09 at 1 am, one week later, the patient called the on-call system for assistance with her ileostomy appliance that started leaking. The surveyor interviewed the patient on 07/07/09, during the interview, the patient stated: "I am so upset. I am never calling the on-call for this agency ever again" The surveyor asked what happened. The patient said "the nurse very abruptly told me 'you must not be emptying the bag enough or this wouldn't be happening'." The patient stated that the way that the nurse spoke to her made her feel very degraded. The patient also stated that when the nurse arrived at the patient's home, she stated "there is no reason why you can't change your own bag, that way we can all get good nights rest". The patient stated that she was very upset regarding the conversation with this nurse.</p> <p>The surveyor interviewed the on-call nurse on 07/08/09 at 09:30 am regarding the on-call visit completed 07/06/09. The surveyor asked the nurse to describe the interaction at the visit. The nurse admitted to the surveyor "I may have been a little curt with the patient". The nurse did not state exactly what she said, but did state "this patient is one of 3 patients that is always calling the nurse in the middle of the night".</p> <p>This information was reviewed with the Administrator and the acting DCM on 07/08/09. The acting DCM stated that the nurse is being placed on a corrective action plan for her patient interaction.</p>	J 236			
J1136	<p>763.11(a)(8)(i) Governing authority</p> <p>763.11 Governing authority.</p>	J1136			

New York State Department of Health

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J1136	<p>Continued From page 3</p> <p>(a)The governing authority shall:</p> <p>....</p> <p>(8) ensure the development and implementation of a patient complaint procedure to include:</p> <p>(i) documentation of receipt, investigation and resolution of any complaint, including maintenance of a complaint log indicating the dates of receipt and resolution of all complaints received by the agency;</p> <p>This Regulation is not met as evidenced by: Based on review of the agency complaint policies and procedures; the agency complaint log dated January 2009 to June 2009; clinical records; and interviews with the Acting Director of Clinical Management (DCM), Manager of Clinical Practice (MCP), Administrator and agency staff, there is no evidence that all complaints are logged and subsequently investigated by the agency.</p> <p>Specifically:</p> <p>A review of the agency's "Complaint Management" Policy NY 3-23 was completed on 07/07/09. The complaint policy states that all complaints will be logged with the dates received and resolved. The agency failed to ensure that all complaints are recorded as per this policy.</p> <p>On 07/07/09, the surveyor requested a copy of the agency's complaint log from the Administrator. The Administrator gave the surveyor a binder which contained pages labeled</p>	J1136	<p>J1136 763.11 (a)(8)(i) GOVERNING AUTHORITY</p> <p>The MCP's conduct weekly team meetings where at all meetings the skilled professional staff were re-educated on the complaint process and importance of documentation of a complaint or potential complaint. This mandatory review was completed by 8/20/09 in all branches, with all disciplines.</p>		08/20/09

10/22/09  
 Acceptable Paul J. Williams

New York State Department of Health

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J1136	<p>Continued From page 4</p> <p>"complaint log". The complaint log contained documentation of complaints received and recorded by the Administrator. The surveyor asked if all of the complaints were in the binder. The Administrator stated that the Liverpool and Auburn complaints were recorded in the binder, but, complaints from the Oswego branch were being faxed to the Liverpool office for the surveyor.</p> <p>On 07/07/09, the surveyor interviewed the Manager of Clinical Practice (MCP) for the Auburn branch. The surveyor asked if the MCP had received any complaints and if so what was the complaint process. The MCP stated that she had taken a complaint on 06/19/09 from a patient's wife. The MCP further explained that she was not sure what to do with the complaint so she "e-mailed the complaint issues to the acting DCM and I am waiting to get a response". The surveyor requested a copy of the e-mail and any other information about the complaint/complaint investigation.</p> <p>On 07/07/09, the acting DCM brought the e-mail to the surveyor. The surveyor asked if there was any other information regarding the complaint or an investigation. The surveyor reviewed the complaint log again to determine if the complaint was logged in, it was not. The acting DCM stated that she did follow-up with the MCP and that the MCP had further information. Two hours later, the acting DCM provided the surveyor a faxed a document labeled "corrective counseling record" dated 06/22/09. Although the counseling form contained a reiteration of the issues in the complaint, there was no evidence of an investigation or resolution or plan to monitor the RN's future patient interaction.</p>	J1136	<p>Recording the status of J1136 763.11 (a)(8)(i) GOVERNING AUTHORITY</p> <p>The MCP staffs conducted an educational in-service at their weekly team meetings concerning documenting and resolving complaints and the complaint process. This mandatory review was completed by 8/20/09 in all branches, with all disciplines.</p> <p>The complaints are now forwarded to the Area Director where a complaint log is maintained for all three branches.</p> <p>A continued pattern of complaints will be discussed by the PAC during their quarterly meetings to recommend any changes in practice or process based on the complaint trends.</p> <p>The disciplinary process will be followed by the branch when a complaint is substantiated and the behavior inappropriate. Continued complaints may lead to termination.</p> <p>Responsible parties: Administrator, ADPS, MCP, and QA Nurse.</p>	

10/22/09  
 acceptable Paula full answers in



New York State Department of Health

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J1136	Continued From page 5 The above issues were reviewed with the Administrator and the acting DCM on 07/07/09. No further information was provided.	J1136			8/20/09



# STATE OF NEW YORK DEPARTMENT OF HEALTH

*Copy*

Central New York Regional Office  
217 South Salina Street Syracuse, New York 13202

Richard F. Daines, M.D.  
Commissioner

James W. Clyne, Jr.  
Executive Deputy Commissioner

December 1, 2009

Denise Rouiller, President  
Hospice and Palliative Care, Inc.  
4277 Middle Settlement Rd.  
New Hartford, NY 13413

Facility: Hospice and Palliative Care, Inc. - New Hartford

Event #: NYKK11

Medicare Provider #: 331510

Type of Survey: Recertification; Complaint Investigation

Survey Exit Date: 10/29/2009

*NY 00075866*  
*NY 000 75240*

Dear Ms. Rouiller:

This office has reviewed the revised Plan of Correction (POC) of November 30, 2009 from the above-referenced survey and determined that the POC is acceptable. It is expected that the plan will be implemented within the time frames indicated. A post-certification visit will be conducted to ensure that the agency has implemented the corrections required.

If you have any questions, please contact Paula Williams at 315-477-8425.

Sincerely,

*Paula Williams for Lynn Shannon*  
Lynn C. Shannon  
Home and Community Based Program Manager

LCS/bjh

cc: Ann Tonzi, Interim Executive Director



# DEPARTMENT OF HEALTH

Central NY Region

217 South Salina Street

Syracuse, New York 13202

Richard F. Daines, M.D.  
Commissioner

James W. Clyne, Jr.  
Executive Deputy Commissioner

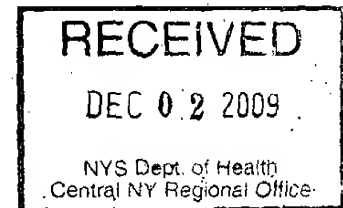
Approved  
Copy  
11/30/09

October 29, 2009

Denise Rouiller, President  
Hospice and Palliative Care, Inc  
4277 Middle Settlement Rd.  
New Hartford, NY 13413

Version  
5  
11/30/09

Facility: Hospice and Palliative Care Inc. - New Hartford  
Event #: NYKK11  
Medicare Provider #: 331510  
Type of Survey: Recertification and Complaint Investigation  
Survey Exit Date: October 29, 2009  
Complaint #: NY00075240 and NY00075866  
Plan of Correction Due Date: **November 9, 2009**  
Termination date: **January 27, 2010**



Dear Ms. Rouiller:

Enclosed is a copy of the Statement of Deficiency (SOD) report resulting from the Article 40 Medicare/Medicaid survey and complaint investigation of your agency by staff from this office. This is being sent to you in your capacity as the Operator of this agency. A copy of the SOD report is being forwarded to the agency's Administrator. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR). Compliance with all Federal and State program requirements is necessary for continued participation in the Medicare/Medicaid programs.

As required by the Center for Medicare and Medicaid Services (CMS), you are being advised that a determination of noncompliance with the Conditions of Participation has been made and that a recommendation is being made to terminate the agency within ninety (90) days of the survey: **January 27, 2010**. The termination process provides an opportunity to make corrections.

A detailed Plan of Correction (POC) must be completed and returned to this office by the above referenced date. The POC should be documented on the right side of the SOD report sent to the administrator and must be *signed and dated on the bottom of the first page*. A copy should be retained for the records of the agency.

Your POC must contain the following for each deficiency cited.

- What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken; What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and
- The date for the correction and the title of the person responsible for correction of each deficiency.


The POC will serve as your agency's credible allegation of compliance. This office will review your POC to determine if the Condition Level issues have been addressed and whether the measures taken would lead your agency to be back in substantial compliance. If your POC is unacceptable, staff from our office will contact you to discuss the items involved.

It is recommended that all corrections should be completed by the fortieth (40) day from the survey exit date. This timetable will allow adequate time for the Department to review the implementation of your POC and conduct a revisit **before the forty-fifth (45) day, December 13, 2009**, to determine whether compliance or acceptable progress has been achieved.

This matter will be referred for possible New York State Public Health Law Section 12 State fines.

If you have any questions, please contact Paula Williams at (315) 477-8425.

Sincerely,



Lynn Shannon  
Home and Community Based Program Manager

KAC/bjh

cc: Glenn Beville, Executive Director

NAME OF PROVIDER OR SUPPLIER <b>HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
L 000	<p><b>INITIAL COMMENTS</b></p> <p>The following statement of deficiencies is the result of a full survey and an onsite investigation of 2 complaints: NY00075866 and NY00075240.</p> <p>Deficient practices were identified at condition level non-compliance in the following 4 Conditions of Participation: Initial and Comprehensive Assessment of the Patient; Interdisciplinary Group, Care Planning, and Coordination of Services; Quality Assessment and Performance Improvement; Organization and Administration of Services. As a result of these deficient practices, negative outcomes were identified for four patients # 1, 7, 8, 13, and the potential for unmet patient needs for the entire agency population.</p> <p>It is also important to note that both complaints listed above are substantiated.</p> <p>A post certification survey of the agency was commenced on August 21, 2009. The post certification survey was initiated as a follow up to the full survey and complaint survey completed on December 1, 2008, event 06PC11 and complaint # NY0059787. On August 24, 2009, it was determined that only one of the citations identified on the December 1, 2008 survey had been corrected, and additional deficiencies were identified in the areas of Comprehensive Assessment, Interdisciplinary Group, and Coordination of Services. The hospice failed to implement their plan of corrective action approved on 01/14/09. A decision was made to conduct a full survey on August 25, 2009.</p> <p>The full survey consisted of a review of a total of 14 clinical records, including 5 observational home visits, and 5 bereavement records.</p>	L 000	<p>This plan of Correction is in response to the Statement of Deficiencies (CMS-2567) received 10/31/2009 based on an extended complaint survey completed on 10/29/2009. This revised Plan of Correction results from phone conversation with by Paula Williams, New York State Department of Health on Friday, November 13, 2009.</p> <p>Hospice and Palliative Care, Inc., New Hartford, is required to submit this Plan of Correction. Doing so, however, does not imply agreement with the citations contained herein nor does it constitute an admission of non-compliance.</p> <p>Hospice and Palliative Care, Inc., New Hartford, is committed to providing compliant, high quality, palliative end-of-life care to eligible Medicare beneficiaries and others with a qualifying life-limiting illness. As such, Hospice and Palliative Care, Inc. retained a nationally known and well respected hospice consulting firm, Weatherbee Resources, Inc. (<a href="http://www.weatherbeeresources.com">www.weatherbeeresources.com</a>), to assist with assessing its level of regulatory compliance and responding to this Statement of Deficiencies.</p> <p>Acronyms and terms used in this Plan of Correction include:          CMS = Centers for Medicare and Medicaid Services          CoP = Condition of Participation          ELNEC = End of Life Nursing Education Consortium          HPCI = Hospice and Palliative Care, Inc.—New Hartford, NY          ICF/MR = Intermediate Care Facilities for the Mentally Retarded          IDG = Interdisciplinary Group          MAR = Medication Administration Record          OFIs = Opportunities for Improvement          PCM = Patient Care Manager          PIPs = Performance Improvement Projects          POC = Plan of Correction          QAPI = Quality Assurance and Performance Improvement          RN = Registered Nurse          SNF/NF = Skilled Nursing Facility/Nursing Facility          SOD = Statement of Deficiency</p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			(X5) COMPLETION DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

NAME OF PROVIDER OR SUPPLIER  <b>HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413</b>		
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L 000	Continued From page 1  Interviews were conducted with the Executive Director, Director of Nursing, Patient Case Managers and members of the interdisciplinary group throughout the survey.  The following agency records were requested and reviewed during the full survey: administrative and clinical policies and procedures, Continuous Quality Improvement meeting minutes from January 2009 to July 2009, Governing Body meeting minutes for 2009, Emergency Preparedness Plan, on-call log, and complaint log.  Additionally, personnel records were reviewed for professional, para-professional and volunteer staff.  Throughout the survey, each clinical record chosen as part of the sample was reviewed with members of the interdisciplinary group, the Executive Director and the Director of Nursing.  Repeat deficient practices were identified in both the previous survey completed on 12/01/08 and current survey completed 10/29/09 and include: incomplete assessments and plans of care; an inadequate quality assurance and performance improvement program that self identifies areas in need of improvement; an interdisciplinary group that failed to provide supervision of hospice care and services; and the inability to provide adequate skilled nursing services.	L000		
L 520	418.54 INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT  This CONDITION is not met as evidenced by:	L520	§ 418.54 INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT	

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Continued From page 1

Interviews were conducted with the Executive Director, Director of Nursing, Patient Case Managers and members of the interdisciplinary group throughout the survey.

The following agency records were requested and reviewed during the full survey: administrative and clinical policies and procedures, Continuous Quality Improvement meeting minutes from January 2009 to July 2009, Governing Body meeting minutes for 2009, Emergency Preparedness Plan, on-call log, and complaint log.

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Throughout the survey, each clinical record chosen as part of the sample was reviewed with members of the interdisciplinary group, the Executive Director and the Director of Nursing.

Repeat deficient practices were identified in both the previous survey completed on 12/01/08 and current survey completed 10/29/09 and include: incomplete assessments and plans of care; an inadequate quality assurance and performance improvement program that self identifies areas in need of improvement; an interdisciplinary group that failed to provide supervision of hospice care and services; and the inability to provide adequate skilled nursing services.

L 520

418.54 INITIAL & COMPREHENSIVE  
ASSESSMENT OF PATIENT

This CONDITION is not met as evidenced by:

To ensure that HPCI conducts an assessment that includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions and documents in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care, the following corrective measures will be completed by the date specified.

1. The hospice will institute an immediate performance improvement project on the comprehensive assessment of the patient and care planning to address the patient's identified needs and to determine areas that contributed to the negative outcomes identified in the Statement of Deficiencies dated 10/29/09. Based on preliminary findings of this performance improvement project, corrective actions provided by hospice leadership include:

Implement  
ed:  
11/20/09

- a. Implementation of new tools for clinical staff to use to comprehensively assess the physical, psychosocial, emotional, and spiritual needs of the patient and family. The new assessment tools will be used in the comprehensive assessment of all future patients.

Implement  
ed:  
11/20/09

- b. The Interim Administrator or designee will monitor the consistent utilization of the new assessment forms.

Implement  
ed:  
11/20/09

L520

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Continued From page 1

L520

Interviews were conducted with the Executive Director, Director of Nursing, Patient Case Managers and members of the interdisciplinary group throughout the survey.

The following agency records were requested and reviewed during the full survey: administrative and clinical policies and procedures, Continuous Quality Improvement meeting minutes from January 2009 to July 2009, Governing Body meeting minutes for 2009, Emergency Preparedness Plan, on-call log, and complaint log.

Additionally, personnel records were reviewed for professional, para-professional and volunteer staff.

Throughout the survey, each clinical record chosen as part of the sample was reviewed with members of the interdisciplinary group, the Executive Director and the Director of Nursing.

Repeat deficient practices were identified in both the previous survey completed on 12/01/08 and current survey completed 10/29/09 and include: incomplete assessments and plans of care; an inadequate quality assurance and performance improvement program that self identifies areas in need of improvement; an interdisciplinary group that failed to provide supervision of hospice care and services; and the inability to provide adequate skilled nursing services.

*11/30/09 acceptable*  
*Paula Williams*

c. The Clinical Supervisor will verbally review patient status with primary nurse after the primary nurse completes the Initial & Comprehensive Nursing Assessment.

Implement  
ed:  
11/20/09  
and  
Ongoing

d. The Clinical Supervisors will review 100% of the comprehensive assessments forms, within 24 hours of receiving completed form.

Implement  
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11/20/09  
and  
Ongoing

e. The existing Documentation Tracking Worksheet will be revised to audit problems identified on assessment, correlation to problems on the patient plan of care and the timeliness and effectiveness of the action plan.

Completed  
11/16/09

f. The Clinical supervisor will notify the ~~Administrator~~ of any clinical issues that need to be addressed, and a special IDG will be held to discuss changes in the plan of care.

Ongoing  
Interim  
Executive  
Director

g. Employees will receive further education and counseling based on individual performance related to assessment and identification of patient problems.

Ongoing

h. Review of the patient

Ongoing

L 520

418.54 INITIAL & COMPREHENSIVE  
ASSESSMENT OF PATIENT

L520

This CONDITION is not met as evidenced by:

page 2b



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Continued From page 1

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Throughout the survey, each clinical record chosen as part of the sample was reviewed with members of the interdisciplinary group, the Executive Director and the Director of Nursing.

Repeat deficient practices were identified in both the previous survey completed on 12/01/08 and current survey completed 10/29/09 and include: incomplete assessments and plans of care; an inadequate quality assurance and performance improvement program that self identifies areas in need of improvement; an interdisciplinary group that failed to provide supervision of hospice care and services; and the inability to provide adequate skilled nursing services.

L 520 418.54 INITIAL & COMPREHENSIVE  
ASSESSMENT OF PATIENTL520  
contExecutive  
Director

comprehensive assessment, plan of care and outcomes will be discussed at the following IDG, documented on the IDG minutes, and changes made to the plan of care.

- i. The Clinical Supervisors and the Director of Clinical Services will identify and report trends to the Administrator. *Executive Director* Ongoing

- j. The Interim Administrator will communicate findings to the QAPI committee at the monthly meeting. Ongoing

2. The QAPI Committee is a Board Level committee that includes the Interim Administrator, the Director of Clinical Services and the Clinical Supervisor. *Executive Director* Implemented: 11/23/09

3. Weatherbee consultants will assist HPCI with the development of an audit tool and with a 100% review of all current patients to ensure that they have received a comprehensive nursing assessment using the new tools. Audit completion: 12/08/09

4. The Clinical Supervisors will continue to review 100% of the comprehensive assessments on new admissions on a weekly basis. *Executive Director* Implemented 11/30/09 And Ongoing

5. The Interim Administrator will provide an in-service to all members of the IDG related to the use of the new comprehensive assessment tools, policies and procedures related to the comprehensive assessment of the patient and documentation requirements. Completed 11/17/07

L520

This CONDITION is not met as evidenced by:

11/30/09  
acceptable *Paula Williams MD*

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L 000	Continued From page 1  Interviews were conducted with the Executive Director, Director of Nursing, Patient Case Managers and members of the interdisciplinary group throughout the survey.  The following agency records were requested and reviewed during the full survey: administrative and clinical policies and procedures, Continuous Quality Improvement meeting minutes from January 2009 to July 2009, Governing Body meeting minutes for 2009, Emergency Preparedness Plan, on-call log, and complaint log.  Additionally, personnel records were reviewed for professional, para-professional and volunteer staff.  Throughout the survey, each clinical record chosen as part of the sample was reviewed with members of the interdisciplinary group, the Executive Director and the Director of Nursing.  Repeat deficient practices were identified in both the previous survey completed on 12/01/08 and current survey completed 10/29/09 and include: incomplete assessments and plans of care; an inadequate quality assurance and performance improvement program that self identifies areas in need of improvement; an interdisciplinary group that failed to provide supervision of hospice care and services; and the inability to provide adequate skilled nursing services.	LS 20 cont	6. Outcome trends from the Comprehensive Assessment of the Patient to be included in the monthly QAPI meeting. PIP (Performance Improvement Projects) developed as recommended by the QAPI committee.	Initiated 11/24/09
			7. Revised policies addressing Comprehensive Assessment of the Patient approved by the Governing Board: <ul style="list-style-type: none"> <li>Assessment-Comprehensive Assessment of the Patient</li> <li>Assessment- Content of the Comprehensive Assessment</li> <li>Assessment-Initial</li> <li>Assessment- Patient Outcome Measures</li> <li>Assessment-Updates to the Comprehensive Assessment</li> </ul>	Completed 11/18/09
L 520	418.54 INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT  This CONDITION is not met as evidenced by:	L520	8. Forms revised to support Comprehensive Assessment of the Patient and approved by the Governing Body: <ul style="list-style-type: none"> <li>Initial and Comprehensive Nursing Assessment</li> <li>Nursing Assessment Update</li> <li>Nursing Clinical Note</li> <li>Physical Pain assessment</li> <li>Skin Impairment Assessment</li> <li>Safety Assessment</li> <li>Fall Risk Assessment</li> <li>Comprehensive Psychosocial Assessment</li> </ul>	Implement ed: 11/18/09

V/  
11/30/09 accept  
Pruitt

Page 2 d

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Continued From page 1

Interviews were conducted with the Executive Director, Director of Nursing, Patient Case Managers and members of the interdisciplinary group throughout the survey.

The following agency records were requested and reviewed during the full survey: administrative and clinical policies and procedures, Continuous Quality Improvement meeting minutes from January 2009 to July 2009, Governing Body meeting minutes for 2009, Emergency Preparedness Plan, on-call log, and complaint log.

Additionally, personnel records were reviewed for professional, para-professional and volunteer staff.

Throughout the survey, each clinical record chosen as part of the sample was reviewed with members of the interdisciplinary group, the Executive Director and the Director of Nursing.

Repeat deficient practices were identified in both the previous survey completed on 12/01/08 and current survey completed 10/29/09 and include: incomplete assessments and plans of care; an inadequate quality assurance and performance improvement program that self identifies areas in need of improvement; an interdisciplinary group that failed to provide supervision of hospice care and services; and the inability to provide adequate skilled nursing services.

L 520 418.54 INITIAL &amp; COMPREHENSIVE ASSESSMENT OF PATIENT

This CONDITION is not met as evidenced by:

L520

- Psychosocial Assessment Update
- Psychosocial/Spiritual Clinical Note
- Comprehensive Spiritual Assessment Spiritual Assessment Update

9. To enhance the skills of clinical staff, HPCI will subscribe to the Hospice Education Network's programs entitled *Initial and Comprehensive Assessment of the Patient* and selected programs on pain management and symptom control. These in-services will be included in

Completion for all current staff: 11/30/09

new staff orientation and as a mandatory annual in-service for members of the IDG. In addition, the ~~Manager of~~ Director Clinical Services or designee will ensure that all current members of the IDG review these in-services and achieve a passing score on the post-tests. [Note: Should the CMS/State Surveyor require access to these educational programs, please contact HPCI for a log-in number and password].

10. Specific data elements related to patient outcome measures are incorporated in the new comprehensive assessment tools.

Included in new tools.

11. These data elements include but are not limited to:

- Assessment within 72 hours of patient response to question: Was your pain brought to a comfortable level within 48 hrs (2 days) after admission.
- Assessment of Skin Integrity, with the identification of Pruritis, Wounds, and Pressure ulcers and compliance with Wound Procedure
- Fall Risk Assessment and Fall rates

Executive Director

12. The Interim Administrator will provide clinical staff with an in-service on documenting the data elements in a systematic and retrievable manner so that the data may be used in individual care planning as well as in the hospice's QAPI program. COMPLETION

Completed 11/17/09

DATE: 11/17/09

Pg 2 e

11/30/09 acceptable Paul Williams RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:  331510		A. BUILDING _____ B. WING _____	C 10/29/2009
NAME OF PROVIDER OR SUPPLIER  HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD				STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413	
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L 520	Continued From page 2 o Failure to ensure that: comprehensive assessments identify the physical, psychosocial, emotional and spiritual needs related to the terminal illness. See L524  o Failure to ensure that: comprehensive assessments are updated by the interdisciplinary group and identify changes that have occurred since the initial assessment; the information includes progress toward desired outcomes and responses to care. See L533  o Failure to ensure that: comprehensive assessment includes data elements that are used to measure outcomes and are used in the care planning and in the coordination of services; the data must be used in the hospice's quality assessment and performance improvement program. See L535, L564.  The cumulative effect of these systemic problems resulted in the hospice's failure to ensure that comprehensive assessments are complete and identify changes in the patient's condition. Additionally, this failure to ensure complete and updated comprehensive assessments has resulted in negative outcomes for four patients: # 1, 7, 8, 13, and potential negative outcomes for the agency's entire patient population.	L 520			
L 524	418.54(c) CONTENT OF COMPREHENSIVE ASSESSMENT  The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.			L524 - begins on page 4.	

P9-3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  331510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/29/2009
NAME OF PROVIDER OR SUPPLIER  HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413		
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L 524	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on a review of 14 clinical records, agency policies and procedures and interviews with agency staff, there is a lack of evidence in 7 records that comprehensive assessments are of sufficient scope to identify patient needs. Patients #4, 7, 8, 9, 12, 13, 14.</p> <p>Failure to ensure complete comprehensive assessment are being conducted has resulted in the inability of the hospice interdisciplinary group to develop individualized care plans that address each patient's total needs. Failure to identify and address specific patient needs has resulted in negative outcomes for three patients, # 7, 8, 13, and the potential for negative outcomes for the agency's entire patient population. Refer to tag L538, which addresses inadequate plan of care development and specific negative outcomes.</p> <p>Examples are as follows:</p> <p>1. Patient # 7 was admitted to the hospice on 07/10/09 with diagnoses of amyotrophic lateral sclerosis (ALS) (Lou Gehrig's Disease) and laryngeal cancer. The comprehensive assessment completed 07/13/09 failed to include the following:</p> <p>- Wound #1 -- primary nurse documented on 7/13/09 that wound was covered with duoderm and was a stage III, based upon caregiver's comment that wound was "through to the bone". SN failed to identify when duoderm had been applied, how frequently it should be changed, or who would be responsible for wound care. On 7/15/09, the primary nurse assessed the wound</p>	L 524	<ol style="list-style-type: none"> <li>As part of the new comprehensive assessment tools, a new form called <b><i>Skin Impairment Assessment</i></b> has been implemented to ensure the comprehensive skin impairment assessment of all patients.</li> <li>The <b><i>Skin Impairment Assessment</i></b> form will be used by nursing staff to assess all current patients to ensure all patients are receiving wound care appropriate to their needs if applicable.</li> <li>Any skin impairment identified for any patient using the new tool will be discussed <u>immediately</u> with the IDG to ensure appropriate and timely intervention.</li> <li>The Interim Administrator will ensure that in-service education is provided to nursing staff members regarding wound care that includes: <ol style="list-style-type: none"> <li>Wound policy and procedure review;</li> <li>Appropriate wound assessment using the <b><i>Skin Impairment Assessment</i></b> form;</li> <li>Wound measurement and staging;</li> <li>Consistent wound documentation;</li> <li>Pressure relieving devices;</li> <li>IDG and patient/caregiver collaboration regarding wound care;</li> <li>Collaboration with nursing facility staff regarding</li> </ol> </li> </ol>	<p>Complete 11/17/09</p> <p>Complete 12/01/09</p> <p>Complete 12/01/09</p> <p>Complete 11/20/09</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  331510	A. BUILDING _____ B. WING _____		COMPLETED  C 10/29/2009
NAME OF PROVIDER OR SUPPLIER  HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413		
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L 524	Continued From page 3  This STANDARD is not met as evidenced by: Based on a review of 14 clinical records, agency policies and procedures and interviews with agency staff, there is a lack of evidence in 7 records that comprehensive assessments are of sufficient scope to identify patient needs. Patients #4, 7, 8, 9, 12, 13, 14.  Failure to ensure complete comprehensive assessment are being conducted has resulted in the inability of the hospice interdisciplinary group to develop individualized care plans that address each patient's total needs. Failure to identify and address specific patient needs has resulted in negative outcomes for three patients, # 7, 8, 13, and the potential for negative outcomes for the agency's entire patient population. Refer to tag L538, which addresses inadequate plan of care development and specific negative outcomes.  Examples are as follows:  1. Patient #7 was admitted to the hospice on 07/10/09 with diagnoses of amyotrophic lateral sclerosis (ALS) (Lou Gehrig's Disease) and laryngeal cancer. The comprehensive assessment completed 07/13/09 failed to include the following:  - Wound #1 - primary nurse documented on 7/13/09 that wound was covered with duoderm and was a stage III, based upon caregiver's comment that wound was "through to the bone". SN failed to identify when duoderm had been applied, how frequently it should be changed, or who would be responsible for wound care. On 7/15/09, the primary nurse assessed the wound	L 524	<p>wound care; and</p> <p>b. Physician communication and plan of care changes.</p> <p><b>Clinical</b></p> <p>5. <del>Patient Care</del> Supervisors will ensure supplies required to implement Wound Care Policy are available to staff.</p> <p>6. As part of the new comprehensive assessment tools, a new form called <b>Physical Pain Assessment</b> has been implemented to ensure the comprehensive assessment of pain for all patients.</p> <p>a. The <b>Physical Pain Assessment</b> form will be used by nursing staff to assess all current patients to ensure patients are receiving pain intervention appropriate to their needs if applicable. <b>Executive Director</b></p> <p>7. The Interim <b>Administrator</b> will ensure that in-service education is provided to all staff members regarding medication administration with focus on the following items:</p> <p>a. Policy/Procedure for Medication Administration;</p> <p>b. Appropriate completion of the Medication Order form;</p> <p>c. Appropriate assessment of medication compliance and use based on patients' physical and mental status to ensure safe and effective medication administration;</p> <p>d. Requirement related to physician orders for medications; and</p> <p>e. IDG and patient/caregiver</p>		<p>Complete 11/17/09</p> <p>Complete 11/17/09</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  331510	(X2) MULTIPLE CORRECTIVE ACTION A. BUILDING _____ B. WING _____		COMPLETED C 10/29/2009
NAME OF PROVIDER OR SUPPLIER  HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413		
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L 524	Continued From page 3  This STANDARD is not met as evidenced by: Based on a review of 14 clinical records, agency policies and procedures and interviews with agency staff, there is a lack of evidence in 7 records that comprehensive assessments are of sufficient scope to identify patient needs. Patients #4, 7, 8, 9, 12, 13, 14.  Failure to ensure complete comprehensive assessment are being conducted has resulted in the inability of the hospice interdisciplinary group to develop individualized care plans that address each patient's total needs. Failure to identify and address specific patient needs has resulted in negative outcomes for three patients, # 7, 8, 13, and the potential for negative outcomes for the agency's entire patient population. Refer to tag L538, which addresses inadequate plan of care development and specific negative outcomes.  Examples are as follows:  1. Patient # 7 was admitted to the hospice on 07/10/09 with diagnoses of amyotrophic lateral sclerosis (ALS) (Lou Gehrig's Disease) and laryngeal cancer. The comprehensive assessment completed 07/13/09 failed to include the following:  - Wound #1 - primary nurse documented on 7/13/09 that wound was covered with duoderm and was a stage III, based upon caregiver's comment that wound was "through to the bone". SN failed to identify when duoderm had been applied, how frequently it should be changed, or who would be responsible for wound care. On 7/15/09, the primary nurse assessed the wound	L 524	collaboration regarding medication administration.  8. A new form called <b>Fall Risk Assessment</b> has been implemented as part of the comprehensive assessment process. a. This form will be used for all future patients. <b>Director</b> b. The <del>Manager</del> of Clinical Services/Clinical Supervisors will monitor the consistent utilization of this form. c. Members of the IDG will receive training with regard to the mandatory use of this form. d. All current patients will be assessed for fall safety using this tool. e. Any patient at risk for fall will be discussed immediately with the IDG to ensure appropriate and timely intervention.  The hospice governing body and the Interim Administrator have determined that pediatric hospice patients will no longer be accepted at HPCI until staff are hired who demonstrate competency working with this specialized population. <b>EFFECTIVE DATE: 11/13/09</b>		Completed 11/20/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:  331510		A. BUILDING _____ B. WING _____		COMPLETED C 10/29/2009	
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L 524	<p>Continued From page 4</p> <p>and documented that it was a stage II. It is unclear how the nurse staged this wound because no depth of the wound bed is recorded.</p> <ul style="list-style-type: none"> <li>- Wound #2 - primary nurse described Wound # 2 as a stage II - 3 cm. left buttock wound. There was no measurement of length, width, or depth.</li> <li>- Communication of needs - primary nurse documented that patient is "oriented x 3" but unable to speak. There is no assessment of how the patient responds to questions and expresses pain.</li> <li>- Pain/pain management. - primary nurse failed to conduct a pain assessment</li> <li>- Personal care needs - primary nurse documented that the patient needed assistance with turning and positioning, bathing and dressing. There is no assessment of who will be responsible.</li> <li>- Respiratory status - no assessment of the patient's tracheostomy stoma; no assessment of the patient's ability to mobilize secretions and the need for suctioning; no assessment of the patient's lung sounds only that the patient had "shallow respirations".</li> <li>- Bowel program. - primary nurse documented "patient unable to go on her own must be digitally removed", however did not identify who will provide bowel care, and the frequency required.</li> <li>- Nutritional status - primary nurse documented that the patient is receiving enteral nutrition through the PEG tube. The feeding is Jevity 1.2 calorie at 60 ml per hour for a total of 1500 ml in</li> </ul>						



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L 524	<p>Continued From page 5</p> <p>24 hours. There is no assessment who is administering the tube feeding, if the person responsible has adequate knowledge or requires additional education regarding care of the PEG tube.</p> <p>An incomplete assessment led to the development of a plan of care that failed to address the patient needs. The patient's integumentary status deteriorated, resulting in development of new open areas.</p> <p>On 08/25/09, the surveyor reviewed this case with the Director of Nursing (DON) and the Executive Director. The DON stated she does not review the comprehensive assessment and was unaware of the patient's deteriorating condition.</p> <p>2. Patient #8, a [REDACTED] was admitted to the hospice on 6/12/09 with a diagnosis of unspecified debility resulting from mitochondrial depletion syndrome. The comprehensive assessment was completed on 06/15/09.</p> <p>Failure to perform complete and comprehensive assessments of the following areas has resulted in the inability of the hospice team to develop an individualized plan of care that addressed caregiver stress, psychosocial needs, and the patient's pain and symptom management:</p> <ul style="list-style-type: none"> <li>- Psychosocial needs of the primary caregiver - the admission nurse documented on 6/12/09 during the initial assessment: "compromised caregiver, conflict within the family, recent deaths" and "this is a very overwhelmed mother ...lost her significant other 1 month ago to sudden death. [REDACTED] The</li> </ul>				

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L 524	<p>Continued From page 6</p> <p>primary nurse failed to assess the potential for psycho/social breakdown and failed to discuss these issues with the social worker who also visited the patient on 06/12/09. The comprehensive assessment completed on 06/15/09 confirmed the above issues and documented that the mother was experiencing a miscarriage. The primary nurse failed to assess the mother's emotional status and feelings of loss relating to her miscarriage, loss of her significant other, and her [REDACTED]</p> <p>- Emotional status of the caregiver relating to the decision to withdraw tube feedings. The primary nurse failed to assess if the mother had discussed her plan to withdraw feedings with the child's attending physician. On 6/12/09, the admission nurse documented that she spoke with the attending physician, who expressed vehement opposition to the mother's plan/decision. On 6/15/09, however, the primary nurse failed to assess if the mother was aware of the attending physician's disagreement with her decision to withdraw feedings</p> <p>- Nutritional status - the primary nurse documented that the mother had made a decision to stop feedings 3 days earlier. The primary nurse failed to assess care of the Mickey button, flushing of the tube, frequency for administration of water through the tube, and the patient's response.</p> <p>- Pain management - primary nurse did not identify how [REDACTED] expresses pain and the type of pain medications used if any.</p> <p>- Respiratory status. The primary nurse documented that the patient had congestion and</p>	L 524		

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L 524	<p>Continued From page 7</p> <p>"raspy" lung sounds, but failed to document respiratory rate and effort.</p> <p>- Neurological status - the primary nurse documented that the patient had a history of seizures and was having "spasms" during the visit. The assessment failed to determine if the spasms observed were the patient's seizures. Additionally, the clinical record contained documentation from the pediatric neurologist who states that the seizures are triggered by loud noises and by touching the patient's foot. There was no assessment of the caregiver's need for education regarding the maintenance of a quiet environment.</p> <p>As a result of the incomplete comprehensive assessment, the agency failed to develop a complete plan of care that promoted comfort and addressed the emotional needs of the mother.</p> <p>On 08/25/09, the surveyor reviewed this case with the Director of Nursing (DON) and the Executive Director. No further information was presented.</p> <p>3. Patient # 13 was admitted to the hospice on 07/07/09 with a terminal diagnosis of cervical cancer and secondary diagnoses of hypertension, depression, anxiety. The comprehensive assessment completed on 07/08/09 failed to address the following:</p> <p>- Anxiety and depression</p> <p>- Fall prevention - the primary nurse documented patient "uses a walker in the home", however, the primary nurse also documented that the patient is waiting for a wheeled walker to be delivered in 2 days. There was no assessment of the patient's</p>		L 524				

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L 524	Continued From page 8 ability to ambulate until the wheeled walker is delivered. The patient fell two days after the comprehensive assessment on 07/10/09  - medication management - the primary nurse documented that the patient needed assistance with medications due to her forgetfulness. The nurse failed to assess the level of assistance necessary to ensure that the patient takes her medications consistently and who would provide assistance  - an assessment of how the patient's personal care needs will be met  - an assessment of the patient's nutritional status. The primary nurse identified that the patient "eats at boyfriend's apartment". There is no assessment of where the boyfriend lives, how the patient gets to his apartment and how many meals are provided by the boyfriend.  This record was reviewed with the DON and Executive Director on 09/10/09. There was no explanation provided to the surveyor regarding the incomplete comprehensive assessment.	L 524			
L 533	418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT  The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of	L533	<b>§ 418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT</b> Please see the corrective actions detailed in L520 and L524 that also address the deficiencies cited at L533. In addition: 1. Weatherbee consultants will assist HPCI in developing an audit tool that will assist clinical staff in conducting record audit of clinical records to ensure that: a. The initial comprehensive		Completion of audit tool: 11/25/09 Audits:

11/30/09  
BWD accept



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10/29/2009

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L 533	<p>Continued From page 10</p> <ul style="list-style-type: none"> <li>- pain/pain management</li> <li>- psychosocial needs and issues</li> <li>- safety</li> <li>- medication compliance</li> </ul> <p>Examples are as follows:</p> <p>1. Patient # 1 was admitted to the hospice on 04/22/09 with a diagnosis of lung cancer and metastasis to the brain.</p> <p>Failure of the hospice nurse to adequately assess the deteriorating coccyx wound and failure to recognize the need to change the plan of care resulted in increased pain, deterioration of the coccyx wound and inadequate pain/pain management.</p> <p>During the admission assessment, the hospice nurse documented that the patient did not have any open areas. It was not until 07/08/09, that the hospice nurse documented that the patient developed a 1.5 centimeter "squared" "cm2" wound that was superficial and that the patient's care giver was applying "Remedy cream and bordered gauze to be changed every 3 days". The primary nurse failed to assess the caregivers competence with wound care.</p> <p>On 07/10/09, the primary nurse visited the patient to deliver supplies. The nurse documented that the patient had complaints of discomfort when sitting in the kitchen chair. The nurse documented that she brought a "donut cushion" for him to use. The hospice nurse failed to assess the patient's buttocks area where he expressed pain when sitting and had an open wound identified on 07/08/09.</p>	L 533		

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L 533	<p>Continued From page 11</p> <p>There were no nursing visits until 07/17/09.</p> <p>On 07/17/09 and 07/22/09, the primary nurse documented that the patient's wound was now 1 "cm2", and a superficial depth, representing a decrease in the size of the wound. The primary nurse documented that the caregiver is applying Remedy cream to the open area not the gauze. There was no evidence that the primary nurse discussed this change in treatment with the IDG or that the physician or the hospice team approved this change in treatment or that this was the best treatment for this wound. There was no visit conducted until 07/30/09, 8 days later.</p> <p>The primary nurse documented that the same wound increased in size with the same depth. Specifically, on 07/30/09, the primary nurse documented that the wound size was now increased to 1.5 "cm2". The primary nurse failed to assess the current treatment ordered and failed to document the wound care she provided if any and failed to assess the patient's pain/pain management. There was no discussion with the team regarding this wound deterioration.</p> <p>On 08/05/09, the primary nurse visited the patient to complete her full assessment and documented that the patient had a pain intensity of 8 on a scale of 0 to 10 in the lower back. The hospice nurse failed to adequately assess the patient to determine if the lower back pain was directly related to the wound or from another source. The primary nurse documented the wound as a stage II - 4 "cm2" in size, with black and white necrotic wound bed and no depth. It is unclear how the primary nurse staged the wound since there was no depth recorded and the wound contained</p>	L 533					

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L 533	<p>Continued From page 12</p> <p>black and white necrotic tissue. The nurse failed to assess the caregiver's competency in providing wound care and failed to document wound care that she provided if any.</p> <p>The primary nurse documented that she educated the primary caregiver to increase the as needed (PRN) pain medication however, failed to identify and discuss with the IDG team and the caregiver the possibility that the lower back pain may be related to the deteriorating wound. The primary nurse failed to assess the need for pressure relieving devices and development of a positioning plan to promote healing and prevent further deterioration of this wound.</p> <p>The primary nurse documented during this visit, "plan made to change dressing to Tender Wet Active for debriding of slough/necrotic wound bed. MD made aware and agrees". Although the primary nurse contacted the physician, she failed to discuss the change in wound treatment with the rest of the IDG team. The primary nurse failed to document if she provided wound care during this visit.</p> <p>On 08/07/09, the primary nurse visited the patient to "demonstrate new sacral decub dressing". The primary nurse failed to assess the wound during the visit and failed to assess caregiver competence with wound care.</p> <p>On 08/09/09, the on-call nurse documented a phone call from the patient's wife stating that the patient was unable to swallow his medication including pain medications. The on-call nurse visited the patient and documented that the patient was again complaining of a pain level of "8 on a scale of 0-10 in his coccyx region". The</p>	L 533			



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L 533	<p>Continued From page 13</p> <p>on-call nurse failed to conduct an adequate pain assessment, failed to turn the patient to assess the location of the pain and failed to determine if the wound had deteriorated.</p> <p>On 08/10/09, the primary nurse visited the patient after receiving report from the on-call nurse and a call from the primary caregiver. Again, the primary nurse failed to assess the status of the coccyx wound even after the on-call nurse reported to her that the location and level of pain. The primary nurse documented that the patient was very weak and lethargic but when asked if having pain stated no pain. There was also no evidence that the primary nurse educated the caregiver about the need to turn and position the patient or assessed the need for pressure relieving mattress for the bed.</p> <p>The primary nurse failed to communicate with the IDG regarding the change in the plan of care and the initiation of intravenous morphine to treat the patient's "back pain".</p> <p>On 08/12/09 the primary nurse visited the patient and observed the wound for the first time in 7 days. The primary nurse documented that the patient's wound had increased in size by 9 "cm2" in seven days and now measured 15 "cm2". The primary nurse now documented that the wound was a stage III was described as "black necrotic, full thickness". Additionally, the primary nurse failed to assess the patient's pain she only documented that the patient was "rigid and tense" The caregiver expressed concerns regarding the patient's agitation behaviors such as "getting up on hands and knees in bed." The primary nurse failed to recognize that the patient's behavior of getting up on hands and knees may be an</p>	L 533			

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L 533	<p>Continued From page 14.</p> <p>attempt to reduce pain in the coccyx area.</p> <p>On 08/13/09, the caregiver states that she found the patient on the floor on his hands and knees. The caregiver informed the primary nurse that she "believes patient is seeking to get himself on the floor so he can position his body to reduce pain." The primary nurse again failed to associate that the patient's attempts to reduce pain by positioning himself on his hands and knees is directly related to the deteriorating coccyx wound.</p> <p>The hospice nurse visited the patient on 08/13, 14, 17, and 19/09. During these visits, the hospice nurse failed to assess the condition of the patients pressure ulcer, the ability of the caregiver to provide wound care and turn and position the patient. The primary nurse discussed and reviewed the number of doses of morphine the patient used however, failed to assess the patient's pain level or location of the patient's pain.</p> <p>Although the primary nurse visited the patient on 08/13, 14, 17, and 19/09, the wound was not assessed or observed between 08/13 and 08/21. On 08/12/09, the wound was recorded as 15 "cm2" and on 08/21/09, the wound now measured 35 "cm2". The primary nurse also documented that the patient now had multiple pressure areas including left ankle, and bilateral hips. The primary nurse still did not identify the need for pressure relieving devices.</p> <p>The failure of the hospice nurse to provide adequate assessment during nursing visits resulted in: the failure to identify a deteriorating coccyx wound, failure to identify the location and</p>	L 533		

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L 533	<p>Continued From page 15</p> <p>source of the patient's increased pain, failure to report the change in condition to the IDG, and failure to implement a plan of care which provides symptom management and alleviates discomfort.</p> <p>On 08/25/09, the surveyor requested to visit the patient with the primary nurse. The visit was scheduled for 08/26/09 at 1 pm. Upon arrival to the hospice on 08/26/08, the surveyor was informed that the patient had expired that morning, therefore, no visit was completed.</p> <p>On 08/25/09, the surveyor interviewed the Director of Nursing (DON) and the Executive Director regarding the above issues. The surveyor asked if the DON was aware of the significant deterioration of the wound? The DON stated no, she didn't know, that she was aware that the patient had a wound but was not aware of the above findings. The surveyor asked the DON to explain what the unit of measure cm squared "cm2" was used to describe the wound size. The DON stated that she didn't know and that the primary nurse would have to answer that question. The surveyor asked if it was part of the policy? The DON stated she didn't know.</p> <p>On 08/26/09 at 12:00 pm, the surveyor interviewed the primary nurse, at the interview was the DON and the Executive Director. The surveyor asked the primary nurse how frequently she observed and measured the patient's wound. The nurse stated that wounds were assessed and measured weekly. The surveyor asked if this was per the policy, the nurse stated that she didn't know what the policy was for wound care. The nurse stated that she was more worried about getting the patient's pain under control than trying to heal the patient's wound because he wasn't</p>		L 533				

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L 533	<p>Continued From page 16</p> <p>eating. The surveyor asked if the nurse recognized that the patient's pain was located in the coccyx region or lower back and if she ever thought that the pain may be related to the deteriorating wound? The nurse stated that she thought that the pain in the lower back may be due to bone metastasis. The clinical record review lacked evidence of the additional bone metastasis. The surveyor also asked why no pressure relieving devices were used? The nurse stated that the patient was not bed bound until recently and didn't need it.</p> <p>The surveyor asked the primary nurse if she received report from the on-call nurse on 08/10/09, the nurse stated yes. The surveyor asked why she (the primary nurse) didn't look at the wound on 08/10/09 when she made her visit if she knew that the patient had pain of 8 out of 10 in the coccyx region from the night before? The primary nurse did not answer.</p> <p>The surveyor asked the primary nurse if she communicated changes in the wound with other team members including the PCM/DON. She stated she did. The surveyor asked the nurse to show documentation of this communication. The nurse looked but could not find any documentation of this communication.</p> <p>The surveyor also asked the primary nurse to explain the units of measure "cm2". The primary nurse explained that because the wound was irregular in shape, "cm2" was equal to the surface area of the wound. The surveyor asked if this was part of the policy, the primary nurse again stated she didn't know but she didn't think so. The agency policy labeled "skin integrity management protocol" dated 12/30/08, does not specify units of</p>	L 533			

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L 533	<p>Continued From page 17</p> <p>measure to be used or the frequency of providing wound care.</p> <p>HV.</p> <p>2. Patient # 7 was admitted to the hospice on 7/10/09, with diagnoses of amyotrophic lateral sclerosis (ALS) and laryngeal cancer. During reassessment visits, the primary nurse failed to ensure complete assessments of wounds, respiratory status, gastric feeding and the patient's inability to make needs known. This resulted in the failure to identify pain and the deterioration of wounds including the PEG tube insertion site.</p> <p>During the comprehensive nursing assessment dated 07/13/09, the primary nurse documented that the patient was unable to speak, required assistance with all personal care; tube feedings administered through a percutaneous endoscopic gastrostomy (PEG) tube; must have digital removal of stool from the rectum for bowel care; has a tracheostomy; and has two open pressure areas.</p> <p>The primary nurse documented the presence of 2 wounds, wound # 1 which she did not observe and described as - covered DuoDerm to a coccyx and "through to the bone" per the caregiver and wound #2 an open pressure area on the left buttocks described as 3 cm with no depth documented that required 3 time a day wound care.</p> <p>The primary nurse visited the patient 2 days later on 07/15/09, assessed the wound and documented that the patient now had 3 open areas as follows:</p>	L 533		

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NAME OF PROVIDER OR SUPPLIER  HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413	
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L 533	<p>Continued From page 18</p> <ul style="list-style-type: none"> <li>- #1 coccyx - stage II - 5 cm x 4 cm</li> <li>- #2 buttocks - stage I - 2 cm x 1.5 cm</li> <li>- #3 right groin inguinal - stage II - 2 cm x 5 cm</li> </ul> <p>Although the primary nurse documented that she assessed wounds #1 and 3 as stage II wounds, the nurse failed to perform an adequate wound assessment by not measuring any depth. The nurse also failed to document the type of wound care provided for each of the 3 wounds, the person responsible and the frequency for wound care. Additionally, the primary nurse failed to assess:</p> <ul style="list-style-type: none"> <li>- the insertion site of the PEG tube or the tolerance of the tube feeding ordered 60 ml/hour. The primary nurse failed to assess the competency of the person providing feedings.</li> <li>- description of the patient's tracheostomy including the amount of suction required to maintain a patent airway</li> <li>- last bowel movement</li> <li>- assessment of the patient's pain/pain management including how the patient who can not speak or move her extremities expresses pain.</li> </ul> <p>There is no evidence that the primary nurse reported the development of a new pressure wound to the IDG.</p> <p>On 07/17/09, the primary nurse documented "home visit to drop off supplies". The primary nurse failed to assess the patient's wounds and failed to document that wound care was provided.</p>	L 533		

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L 533	<p>Continued From page 19</p> <p>The primary nurse inappropriately documented without assessing the wound that: "coccyx area continues to deteriorate, Calmo septine cream being used but patient refuses to be off her back for repositioning". There is no assessment of the wounds documented on 07/15/09.</p> <p>On 07/20/09 the primary nurse visited the patient in response to a call from the primary caregiver. The primary nurse documented that the patient was resting comfortably and that "they (family) are concerned because her coccyx area is not healing". The primary nurse also documented that the family is concerned that the feedings not being tolerated and that the "insertion site of the PEG tube is draining yellow/green drainage". The primary nurse failed to assess the PEG tube insertion site, and failed to clarify what the caregiver determined that the patient wasn't tolerating feedings. There is also no evidence that the primary nurse assessed the caregiver's knowledge of PEG tube insertion site care or observed care provided.</p> <p>The primary nurse failed to contact any members of the hospice team to discuss the issues related to the new PEG tube insertion site drainage and the caregivers statement that the patient is not tolerating feedings.</p> <p>On 07/21/09 the Director of Nursing (DON) documented that she received new physician orders for antibiotics for the infected PEG tube insertion site and orders to cleanse the surrounding skin with Betadine and hydrogen peroxide twice a day and apply a topical antibiotic to the skin. Because the DON obtained physician orders, she called the family to "make them aware of the changes in the orders". There was</p>	L 533					

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L 533	<p>Continued From page 20</p> <p>no assessment of the caregivers ability to provided this care and no discussion with the primary nurse to ensure that an assessment visit would be completed timely. Failure to assess the caregiver's ability to provide the new treatment may result in a delay in treatment provided and worsening drainage.</p> <p>On 07/22/09, the primary nurse documented that she received a "frantic phone call" from the patient's sister stating "patient's lips turned blue and her hands were ringing wet". The primary nurse visited the patient and documented "skin is cool and clammy, breaking down in the coccyx area and she had an infection around her peg tube site." The primary nurse failed to assess: the coccyx wound; the PEG tube insertion site; caregiver's ability to provide cleansing to the PEG tube insertion; and the amount of feeding the patient is absorbing. The failure to provide an adequate assessment of the patient resulted in: failure to identify changes in the patient condition with respect to a deteriorating coccyx wound and an infected PEG tube insertion site; and failure to develop a plan of care which addressed the patient's needs.</p> <p>On 07/30/09, the on-call LPN stopped at the patient's home to deliver supplies. Upon arrival, the family voiced concerns that the patient had a very large "bedsore". The LPN documented that with the assistance of the private hire caregiver, she positioned the patient on her side and noted a wound on coccyx. The LPN called the on-call RN who visited the patient. The LPN documented that the on-call RN measured the coccyx wound as 4 cm x 3.2 cm with no depth and no description of the wound bed or drainage. The LPN documented that the RN "cleansed the</p>	L 533		



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L 533	<p>Continued From page 21</p> <p>wound and applied a temporary covering." There was no visit note from the on-call RN in the clinical record, no call to the patient case manager or the physician to determine the type of wound care to be applied. There was no assessment of the the other two wounds identified 15 days ago on 07/15/09.</p> <p>The primary nurse visited the patient the following day on 07/31/09 and documented that the patient now had two wounds.</p> <p>The two wounds identified during this visit were described as a small wound near the tracheostomy stoma and a stage III coccyx measuring measured 5 cm x 5 cm with an odor. The primary nurse failed to assess the condition of the inguinal and left buttocks wound identified on 07/15/09.</p> <p>The primary nurse failed to assess determine if the care giver was providing wound care; the frequency of wound care provided and the type of dressing ordered. The nurse also failed to assess the insertion site of the PEG tube that was draining yellow/green drainage on 07/20/09 and failed to assess if treatment ordered on 07/21/09 is being provided.</p> <p>On 08/06/09, the primary nurse visited the patient to assess the coccyx wound and documented that the wound was now 5 cm x 6 cm with tunneling, moderate drainage and an odor. The nurse documented that she contacted the "wound care specialist" who suggested new orders. The primary nurse did not document the type of wound care that she provided and failed to communicate with the hospice team that the wound now had tunneling and to ensure that a</p>	L 533					

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331510

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

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10/29/2009

NAME OF PROVIDER OR SUPPLIER

HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD

STREET ADDRESS, CITY, STATE, ZIP CODE

4277 MIDDLE SETTLEMENT ROAD

NEW HARTFORD, NY 13413

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L 533	<p>Continued From page 22</p> <p>plan was developed that addressed appropriate wound care.</p> <p>The primary nurse failed to provide any other patient assessment. Specifically, there was no assessment of the PEG tube insertion site, the tracheostomy stoma, the patient's respiratory status, pain or how she makes her needs known and answers questions due to her inability to speak and or move her extremities.</p> <p>There was no nursing visit for 7 days until 08/13/09, the primary nurse documented that the patient's coccyx wound measured 5 cm x 4 cm with tan drainage, no odor, and no further tunneling. There was no documentation of the wound care provided. The primary nurse only documented that she informed the family "do not remove dressing". The primary nurse did not instruct the family to call hospice if the dressing became dislodged or give instruction to keep the wound clean. The primary nurse failed to assess the patient's ability to express pain or make her needs known related to the fact that she cannot speak or move her extremities.</p> <p>The primary nurse failed to visit the patient again until 5 days later on 8/18/09. During the visit, the primary nurse failed to correctly label the new wounds; failed to adequately measure each wound, and/or describe the treatment provided for each wound identified.</p> <p>#1 - stage III coccyx wound. There was no depth measurement for this wound that had worsened from a stage II to a stage III. The wound measured 4 cm round, the nurse failed to document a wound depth, therefore, it is unclear</p>	L 533		

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L 533	<p>Continued From page 23</p> <p>upon what basis the nurse noted that the wound was a stage III.</p> <p>#2 - located on the left shoulder - measuring 0.5 cm (was previously a buttocks wound on 07/15/09)</p> <p>#3 - described as a rash under the patient's breasts not measured and not described on "weekly skin assessment sheet" (was previously described as a inguinal wound on 07/15/09)</p> <p>#4 - the PEG tube insertion site (was never labeled as a wound) The primary nurse failed to assess caregiver's ability to provide care.</p> <p>#5 - somewhere on the patient's back and described as multiple red areas not measured. The nurse failed to describe the exact location of the multiple red areas on the back.</p> <p>#6 - chafing under arms bilaterally. The nurse failed to assess and describe the extent of the chafing and assess for preventative measures.</p> <p>The primary nurse failed to assess the treatment used for each wound or the caregiver's ability to provide wound care was not assessed or observed.</p> <p>There was no assessment of the patient's pain/pain management or an assessment of the patient's ability to answer questions or make her needs known when she can not speak or move her extremities.</p> <p>On 08/26/09, the surveyor conducted an observational home visit with the primary nurse. During the visit, the patient was found lying on her</p>	L 533			

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L 533	<p>Continued From page 24</p> <p>back. The primary nurse with the assistance of the caregiver turned the patient and found that there was no dressing on the wound. The primary nurse asked the caregiver what happened to the dressing. The caregiver stated that the dressings became soiled so they removed them. The primary nurse failed to assess how long the dressing was off or why the care giver failed to notify the hospice. She stated that the dressings frequently become soiled and that they (the caregiver) either put bacitracin on the wound or just leave it open to air.</p> <p>The primary nurse measured the coccyx wound and told the surveyor "it is much larger than the previous visit". However, a review of the documentation from the 08/26/09 visit by the primary nurse states that the wound is 3 cm in size which is 1 cm smaller than the 08/18/09 visit. The primary nurse documented that the open area of the wound was 3 cm in size however, the reddened area was 8 cm x 11 cm.. This is the first documentation of any reddened area around the coccyx wound.</p> <p>The primary nurse failed to consistently assess the patient's wound, PEG tube drainage even after the patient was placed on antibiotics, failed to ensure that the visit frequency was adequate to assess compliance with the plan of care by the caregivers; failed to communicate changes in the patient's condition to the Patient Care Manager and the other members of the hospice team. The primary nurse failed to assess caregiver competence in providing care which resulted in inconsistent wound treatments and an increase in the size of the reddened area of the skin which is a precursor to skin breakdown.</p>		L 533				

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L 533	<p>Continued From page 25</p> <p>This record was reviewed with the DON and Executive Director on 08/25/09 and again on 08/26/09. The results of the observational home visit were discussed with the DON following the visit on 08/26/09. The surveyor conveyed concerns regarding the coordination with the caregivers in the home and the primary nurse's failure to reinforce teaching regarding wound care.</p> <p>3. Patient # 13 was admitted to the hospice on 07/07/09 with a primary diagnosis of cancer of the cervix and secondary diagnoses of depression, anxiety, and acute renal failure. The patient lives alone in an apartment. The hospice nurse failed to ensure that comprehensive assessments were updated and that the patient's needs were being met including medication management, falls prevention and personal care.</p> <p>Failure to ensure an adequate assessment of the patient's safety resulted in: a fall with injuries and the inability to remain in her home. The primary nurse failed to provide an adequate assessment of the patient's medication compliance and her ability to provide personal care.</p> <p>Specifically, the initial and comprehensive assessments completed on 07/07 and 07/08/09 respectively indicate that the patient was forgetful, lived alone, had an unsteady gait and was awaiting delivery of a wheeled walker for ambulation safety on 07/10/09. The hospice failed to ensure that the patient was safe without the wheeled walker and the patient subsequently fell on 07/10/09 and hit her nose as reported to the nurse by the volunteer coordinator.</p>	L 533			

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L 533	<p>Continued From page 26</p> <p>The primary nurse failed to visit the patient to assess any injuries that may have occurred as a result of the fall.</p> <p>On 07/13/09, the social worker called the patient's daughter and documented that the patient was staying at the daughters home for a few days after the fall. The social worker documented that he reported this information to the primary nurse on 07/13/09. The primary nurse failed to contact the patient until 07/16/09 and failed to discuss falls with members of with the IDG team.</p> <p>On 07/16/09, the primary nurse documented that she contacted the daughter and that the patient was still staying at the daughter's home and daughter stated that the patient had no further falls. The primary nurse failed to visit the patient at the daughter's home to assess the patient's safety and failed to determine if the patient is appropriate to move back to her own apartment alone.</p> <p>The primary nurse failed to visit the patient until 07/22/09, after she returned to her own home, 12 days after the fall.</p> <p>During the visit on 07/22/09, the primary nurse failed to assess the patient's home safety and failed to assess the following:</p> <ul style="list-style-type: none"> <li>- patient's ability to use the wheeled walker in the home</li> <li>- compliance with medication administration.</li> </ul> <p>The patient states that she does not want a medication box, however, the primary nurse failed</p>			L 533			

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L 533	<p>Continued From page 27</p> <p>to assess how the patient would remember to take her medication as ordered.</p> <ul style="list-style-type: none"> <li>- an assessment of her nutritional status including further investigation of how patient obtains her meals. The primary nurse documented that the patient eats at her boyfriend's apartment, but there is no discussion of how the patient gets to her boyfriend's apartment and no assessment of whether this meets her nutritional needs.</li> <li>- an assessment of the patient's ability to provide personal care. Specifically, the primary nurse documented that the patient's apartment has a strong odor of urine. The nurse did not assess if the odor was from incontinence or if the patient had difficulty ambulating to the bathroom.</li> <li>- an assessment of the willingness and availability of the patient's daughter to assist with care. There was no discussion of the patient's status with the team and no subsequent plan to keep the patient safe in her home.</li> </ul> <p>There was no assessment visit until 08/07/09, 16 days later. During the visit the hospice nurse failed to assess the patient's use of the walker, overall medication compliance even after the patient stated that she could not remember if she used her inhalers. The hospice nurse documented that the patient was agreeable to have daughter set up medications, however, there was no assessment of the daughters willingness or availability to provide care.</p> <p>The primary nurse documented that the patient was not dressed when she arrived at the patient's</p>	L 533					

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L 533	<p>Continued From page 28</p> <p>home. The nurse failed to assess if the patient had showered or bathed and failed to document if she assisted the patient with personal care during the visit.</p> <p>The primary nurse failed to assess the patient's nutritional status and documented that the patient vomited yesterday, "states she eats junk food" as an explanation for why she vomited. The nurse failed to assess if the patient was able to obtain food and if she had been eating. The nurse documented that the patient agreed to a home health aide twice a week. Failure of the primary nurse to assess the patient's ability to live alone and to discuss the patient's safety with the team resulted in the patient's deteriorating condition and failure to ensure that her needs were met.</p> <p>The primary nurse failed to visit the patient to assess on-going medication compliance until 11 days later. On 08/18/09, the nurse documented that the patient again forgot her medications, failed to document which medications forgotten and failed to address overall medication compliance. The nurse also documented that there was a strong smell of urine in the home however, did not assess if the smell was from the patient, her apartment or the patient's cat. The nurse failed to assess the patient's nutritional status including the ability to obtain food or if the patient continues to eat meals at the boyfriend's. The primary nurse failed to recognize that the patient required an increase in supervision of medications, meals and personal care and failed to failed to conduct an assessment visit until 14 days later.</p> <p>On 08/24/09, the social worker visited the patient</p>	L 533			



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L 533	<p>Continued From page 29</p> <p>and identified that the patient was "disheveled, had not bathed in some time, and was not taking her medications. The social worker discussed this with the primary nurse however, there was no visit completed by the primary nurse to assess the patient's medication compliance and safety until 09/01/09.</p> <p>On 08/31/09, the social worker visited the patient again the social worker documented that the patient was still lying in bed at 1:15 pm. The social worker asked the patient if she had eaten today, she stated yes she had eaten earlier in the day but she was hungry. The social worker found food in the refrigerator which she heated up. The social worker also documented that she was concerned that the patient was depressed, not eating well and not taking her medication and not receiving adequate care to assure her well being. The social worker contacted the patient care manager however, there was no discussion with the primary nurse.</p> <p>On 09/01/09, the primary nurse and the social worker visited the patient and again identified that the patient did not take her medication. The nurse documented that the patient's blood pressure was elevated to 150/100, there were saturated attends on the floor, and no food in her apartment. Based on this assessment and the social worker assessment of 08/31/09, the interdisciplinary group decided that the patient should be transferred to the hospice residence.</p> <p>On 09/02/09, the surveyor visited the patient at the hospice residence. The patient stated that she did not want to move from her home, and her cat. The primary nurse and social worker failed</p>	L 533					

## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

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L 533	Continued From page 30 to update comprehensive assessments and develop a plan to address patient's on-going medication non-compliance and decreasing ability to meet her personal care needs.  This record was reviewed with the DON, Executive Director and the patient case manager on 09/10/09. The patient case manager stated that she believed that the patient's daughter was managing the patient's medications however, there was no assessment of the daughters availability or willingness to provide assistance. There was no explanation regarding the other nursing issues.	L 533			
L 535	418.54(e)(2) PATIENT OUTCOME MEASURES  (2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.  This STANDARD is not met as evidenced by: Based on a review of comprehensive assessments in 14 clinical records, policy and procedures and interviews with Director of Nursing (DON) and Executive Director there is no evidence in 14 records that the agency has specified data elements to measure patient outcomes, assist in individual care planning or in the quality improvement program to evaluate outcomes.  Failure to ensure that the hospice has a	L535	<p>§ 418.54(e)(2) PATIENT OUTCOME MEASURES</p> <p>Please see the corrective actions at L520 (1c) that also addresses the deficiencies cited at L535. In addition:</p> <ol style="list-style-type: none"> <li>1. A process for aggregating the data from individual patient assessments will be determined by the QAPI Committee so that the data may be used in the hospice's QAPI program.</li> <li>2. This process will include data from audit of active patients, utilizing the new audit tool, as of 12/1/09.</li> <li>3. The QAPI Committee will track and analyze this data to identify trends and identify opportunities for improvement (OFIs). When OFIs are identified, the QAPI Committee will develop performance improvement projects (PIPs) as part of its QAPI program.</li> </ol>		<p>Completed: 11/16/09</p> <p>Ongoing</p> <p>Ongoing</p>

## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  331510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/29/2009
NAME OF PROVIDER OR SUPPLIER  HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 535	Continued From page 31 mechanism for retrieving data to measure patient outcomes has the potential for unmet patient needs and negative patient outcomes.  On 09/01/09, the surveyor interviewed the DON and requested a copy of the policy related to data elements and outcome measures. The DON stated that they do not have a specific policy regarding this.  The surveyor asked for the Quality Assessment and Performance Improvement (QAPI) policy from the DON on 09/11/09. The DON stated that they do not have a specific policy for QAPI.  A review of the agency's Quality Management Manual dated 06/24/05 was completed on 09/11/09. The manual contains policies labeled Outcome Measurements. The outcome measurements specified in the policy manual only includes data obtained from patient satisfaction surveys, not on measurable data elements from the clinical record/ comprehensive assessments. The hospice did not update the policies and procedures to reflect the requirements of the new CMS Conditions of Participation effective 12/02/08.	L 535	4. Upon completion of PIPs for the initial OFI, 10% of the current ADC will be reviewed monthly to identify sustained compliance and ongoing, as determined by the QAPI committee and approved by the governing body. 5. Initial selected outcome measures include safe and comfortable dying as identified by: <ul style="list-style-type: none"> <li>Pain brought to a comfortable level within 48 hrs (2 days) after admission.</li> <li>Skin Impairment Assessment completed if wounds present.</li> <li>Wound treatment compliant with HPCNY procedure and/or physician orders.</li> <li>Fall Risk Assessment completed on at-risk patients</li> <li>Witnessed and unwitnessed falls documented on (occurrence?) form and appropriate action incorporated in the Plan of Care by the IDG.</li> </ul>	Implement: 12/8/09	
L 536	418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES  This CONDITION is not met as evidenced by: <ul style="list-style-type: none"> <li>Failure to ensure that plans of care specify the care and services necessary to meet the patient/family needs as identified in the comprehensive assessments See L538</li> <li>Failure to ensure that the interdisciplinary group provides the care and services offered by</li> </ul>		6. The data collected from the patient's comprehensive assessment is used to provide individualized care planning, appropriate interventions and for the coordination of services for each patient.	Ongoing	

11/30/09 acceptable PGM

## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

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L 535	<p>Continued From page 31</p> <p>mechanism for retrieving data to measure patient outcomes has the potential for unmet patient needs and negative patient outcomes.</p> <p>On 09/01/09, the surveyor interviewed the DON and requested a copy of the policy related to data elements and outcome measures. The DON stated that they do not have a specific policy regarding this.</p> <p>The surveyor asked for the Quality Assessment and Performance Improvement (QAPI) policy from the DON on 09/11/09. The DON stated that they do not have a specific policy for QAPI.</p> <p>A review of the agency's Quality Management Manual dated 06/24/05 was completed on 09/11/09. The manual contains policies labeled Outcome Measurements. The outcome measurements specified in the policy manual only includes data obtained from patient satisfaction surveys, not on measurable data elements from the clinical record/ comprehensive assessments. The hospice did not update the policies and procedures to reflect the requirements of the new CMS Conditions of Participation effective 12/02/08.</p>	L 535	<p>7. The data is reviewed by the Clinical Supervisors, entered by <del>Administrative</del> <i>Administrative</i> support into the QAPI Navigator, which provides aggregation and benchmarking, submitted to the QAPI committee for analysis one week prior to the monthly meeting and recommendations are presented to the Governing Board monthly meeting. <i>Executive Director</i></p> <p>8. The Interim Administrator is notified by the Clinical Supervisors of immediate individual patient needs. <i>Ongoing</i></p> <p>9. The QAPI Navigator is used to provide real-time data and on-demand reporting. It includes:</p> <ul style="list-style-type: none"> <li>• 40 industry-recommended quality measures</li> <li>• Prescribed patient-level data elements automatically aggregated for reporting.</li> <li>• Real-time data capture and on-demand comparative reporting</li> <li>• This web-based clinical tool set is comprised of multiple modules. Each module captures and aggregates patient data and reports hospice quality measures for compliance with Medicare CoPs and identification of performance improvement opportunities. The modules analyze both clinical and non-clinical functions of the hospice.</li> </ul> <p><i>Implement use: 12/1/09</i></p>		<i>Ongoing</i>
L 536	<p>418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES</p> <p>This CONDITION is not met as evidenced by:</p> <ul style="list-style-type: none"> <li>o Failure to ensure that plans of care specify the care and services necessary to meet the patient/family needs as identified in the comprehensive assessments See L538</li> <li>o Failure to ensure that the interdisciplinary group provides the care and services offered by</li> </ul>				

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DEPARTMENT OF HEALTH SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  331510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/29/2009
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L 535	<p>Continued From page 31</p> <p>mechanism for retrieving data to measure patient outcomes has the potential for unmet patient needs and negative patient outcomes.</p> <p>On 09/01/09, the surveyor interviewed the DON and requested a copy of the policy related to data elements and outcome measures. The DON stated that they do not have a specific policy regarding this.</p> <p>The surveyor asked for the Quality Assessment and Performance Improvement (QAPI) policy from the DON on 09/11/09. The DON stated that they do not have a specific policy for QAPI.</p> <p>A review of the agency's Quality Management Manual dated 06/24/05 was completed on 09/11/09. The manual contains policies labeled Outcome Measurements. The outcome measurements specified in the policy manual only includes data obtained from patient satisfaction surveys, not on measurable data elements from the clinical record/ comprehensive assessments. The hospice did not update the policies and procedures to reflect the requirements of the new CMS Conditions of Participation effective 12/02/08.</p>	L 535	<p><i>The addendum The web based tool will be implemented but collection for aggregating will be ongoing. Raw chart audit data will be available for review.</i></p> <p><i>✓ accept 11/30/09 AN</i></p>	
L 536	<p>418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES</p> <p>This CONDITION is not met as evidenced by:</p> <ul style="list-style-type: none"> <li>o Failure to ensure that plans of care specify the care and services necessary to meet the patient/family needs as identified in the comprehensive assessments See L538</li> <li>o Failure to ensure that the interdisciplinary group provides the care and services offered by</li> </ul>			

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L 535	Continued From page 31 mechanism for retrieving data to measure patient outcomes has the potential for unmet patient needs and negative patient outcomes.  On 09/01/09, the surveyor interviewed the DON and requested a copy of the policy related to data elements and outcome measures. The DON stated that they do not have a specific policy regarding this.  The surveyor asked for the Quality Assessment and Performance Improvement (QAPI) policy from the DON on 09/11/09. The DON stated that they do not have a specific policy for QAPI.  A review of the agency's Quality Management Manual dated 06/24/05 was completed on 09/11/09. The manual contains policies labeled Outcome Measurements. The outcome measurements specified in the policy manual only includes data obtained from patient satisfaction surveys, not on measurable data elements from the clinical record/ comprehensive assessments. The hospice did not update the policies and procedures to reflect the requirements of the new CMS Conditions of Participation effective 12/02/08.				
L 536	418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES  This CONDITION is not met as evidenced by: o Failure to ensure that plans of care specify the care and services necessary to meet the patient/family needs as identified in the comprehensive assessments See L538  o Failure to ensure that the interdisciplinary group provides the care and services offered by	L536 and L538	§ 418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES In addition to related corrective actions detailed at L524 and L591, the following corrective actions address the deficiencies cited at L536:  1. Weatherbee consultants will assist HPCI with the development of an audit tool to ensure all patients have a plan of care that is based on their assessed needs, accurately reflects the patient's problems, interventions and goals and the scope and frequency of services needed to address the patient's needs. Clinical staff will utilize this tool on an ongoing basis to monitor each patient's clinical record and plan of care.	Comple tool: 11/24/09	

11/30/09 acceptable  
Pw

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# CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  331510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/29/2009
NAME OF PROVIDER OR SUPPLIER  HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413		
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L 536	<p>Continued From page 32</p> <p>the hospice, and the group, in its entirety, supervises the care and services provided by the hospice. L539</p> <p>o Failure of the hospice to ensure that the registered nurse assigned to provide coordination of care is: ensuring continuous assessment of needs and implementation of the interdisciplinary plan of care. See L540</p> <p>o Failure of the hospice to ensure the development and implementation of an individualized plan of care established by the interdisciplinary group in collaboration with the attending physician. See L543, L545</p> <p>o Failure of the hospice to ensure that the interdisciplinary group develops an individualized plan of care that includes: interventions to manage pain and symptoms; a detailed statement of the scope and frequency of services necessary to meet the patient and family needs; measurable outcomes resulting from implementing and coordinating the plan of care. See L548</p> <p>o Failure of the hospice to ensure that the plan of care is reviewed and revised by the interdisciplinary group as frequently as necessary, that revisions include information obtained from the updated comprehensive assessment and note the patient's progress toward outcomes and goals specified in the plan of care. See L553.</p> <p>The cumulative effect of these systemic problems resulted in the hospice's failure to ensure that plans of care are developed to meet the needs of</p>	L 536	<p>2. The Director of Clinical Services will ensure that all current and future members of the IDG review the Hospice Education Network's program <i>IDG, Care Planning and Coordination of Services</i>. Members of the IDG will be required to receive a passing score on the post test for this in-service.</p> <p>3. The QAPI Committee will conduct a performance improvement project on care planning at HPCI. The performance improvement project will include:</p> <p>a. A thorough review of tools/forms, structure of IDG meetings, and staff competency related to assessment and care planning to determine areas that contributed to the negative outcomes identified in the Statement of Deficiencies dated 10/29/09.</p> <p>b. Revision of care planning and IDG tools and forms to ensure they provide for the individualization of the patient's plan of care that includes interventions to manage pain and symptoms, detailed scope and frequency of services and measurable outcomes;</p> <p>c. In-service related to the use of revised tools and documentation of measurable outcomes;</p>	<p>Completion n: 11/30/09</p> <p>Completion n 12/1/09</p> <p>Implement : 11/30/09 and ONGOING</p> <p>Completion n: 11/30/09</p>	

*acceptable*  
*11/30/09*  
*Paula Williams RN*

*pg 32 a*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  331510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		COMPLETED  C 10/29/2009
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L 536	Continued From page 32 the hospice, and the group, in its entirety, supervises the care and services provided by the hospice. L539  o Failure of the hospice to ensure that the registered nurse assigned to provide coordination of care is: ensuring continuous assessment of needs and implementation of the interdisciplinary plan of care. See L540  o Failure of the hospice to ensure the development and implementation of an individualized plan of care established by the interdisciplinary group in collaboration with the attending physician. See L543, L545  o Failure of the hospice to ensure that the interdisciplinary group develops an individualized plan of care that includes: interventions to manage pain and symptoms; a detailed statement of the scope and frequency of services necessary to meet the patient and family needs; measurable outcomes resulting from implementing and coordinating the plan of care. See L548  o Failure of the hospice to ensure that the plan of care is reviewed and revised by the interdisciplinary group as frequently as necessary; that revisions include information obtained from the updated comprehensive assessment and note the patient's progress toward outcomes and goals specified in the plan of care. See L553.  The cumulative effect of these systemic problems resulted in the hospice's failure to ensure that plans of care are developed to meet the needs of	L 536	d. Revision of IDG meeting agenda and format to ensure that the IDG reviews and revises the patient's plan of care based upon updated comprehensive assessments and the patient's progress toward outcomes and goals.  Revision of IDG meeting agenda and format to ensure that the IDG reviews and revises the patient's plan of care based upon updated comprehensive assessments and the patient's progress toward outcomes and goals.	Completion n: 11/11/09  Implementation 11/11/09	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0001

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  331510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/29/2009
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L 536	<p>Continued From page 32</p> <p>the hospice, and the group, in its entirety, supervises the care and services provided by the hospice. L539</p> <p>o Failure of the hospice to ensure that the registered nurse assigned to provide coordination of care is: ensuring continuous assessment of needs and implementation of the interdisciplinary plan of care. See L540</p> <p>o Failure of the hospice to ensure the development and implementation of an individualized plan of care established by the interdisciplinary group in collaboration with the attending physician. See L543, L545</p> <p>o Failure of the hospice to ensure that the interdisciplinary group develops an individualized plan of care that includes: interventions to manage pain and symptoms; a detailed statement of the scope and frequency of services necessary to meet the patient and family needs; measurable outcomes resulting from implementing and coordinating the plan of care. See L548</p> <p>o Failure of the hospice to ensure that the plan of care is reviewed and revised by the interdisciplinary group as frequently as necessary; that revisions include information obtained from the updated comprehensive assessment and note the patient's progress toward outcomes and goals specified in the plan of care. See L553.</p> <p>The cumulative effect of these systemic problems resulted in the hospice's failure to ensure that plans of care are developed to meet the needs of</p>				

## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

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L 536	Continued From page 33 the patient and that the interdisciplinary group supervises care and services provided as outlined in the plan of care. Additionally, failure of the interdisciplinary group to develop and supervise the care delivered to hospice patients resulted in negative outcomes for 4 patients # 1, 7, 8, 13 and potential negative outcomes for the agency's entire patient population.	L 536			
L 538	418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES  The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.  This STANDARD is not met as evidenced by: Based on a review of 14 clinical records, policies and procedures and interviews with agency staff there is no evidence in 9 records that the hospice interdisciplinary group develops an individualized plan of care which addresses the needs of the patient and family as identified in the comprehensive assessment. Patients # 2, 3, 4, 5, 7, 8, 11, 13, 14  Failure to ensure that the interdisciplinary group develops individualized plans of care that address and meet the physical and psycho/social needs of the patient and family has resulted in negative outcomes for patients # 7, 8, 13 and the potential for negative outcomes for the agency patient population.  Specifically:  1. Patient # 8, a [REDACTED] was admitted to the hospice on 06/12/09 with a diagnosis of	L 538	§ 418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES  Please refer to L536 # 1  <i>refer to 536b</i> <i>The initial and</i> <i>comprehensive</i> <i>assessments will</i> <i>be used to develop</i> <i>the plan of</i> <i>care. The plan</i> <i>of care will</i> <i>reviewed ongoing</i> <i>at the IDG</i> <i>meetings.</i>		

*addition requested up to*  
*page 34*  
*Ann [Signature]*  
*Executive Director*

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

331510

(X2) MULTIPLE COMPLETION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

COMPLETION

C

10/29/2009

NAME OF PROVIDER OR SUPPLIER

HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD

STREET ADDRESS, CITY, STATE, ZIP CODE

4277 MIDDLE SETTLEMENT ROAD  
NEW HARTFORD, NY 13413(X4) ID  
PREFIX  
TAGSUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
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PREFIX  
TAGPROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)(X5)  
COMPLETION  
DATE

L 538

Continued From page 34

unspecified debility resulting from mitochondrial depletion syndrome. Failure of the team to develop an adequate plan of care that addressed the needs of the caregiver and the patient resulted in increased and prolonged pain and discomfort for the child and increased caregiver stress.

Specifically, the plan of care failed to address the following issues:

- caregiver stress related to the debilitating illness and terminal condition of her [REDACTED]

- psychosocial needs of the primary caregiver. The mother was identified as the primary caregiver. The comprehensive assessment states: "compromised caregiver, conflict within the family, recent deaths" and "this is a very overwhelmed mother ...lost her significant other 1 month ago to sudden death..." [REDACTED]

The assessment also states that the mother is having a miscarriage. The plan of care did not address these issues and did not include a plan for social work, spiritual care, volunteers or bereavement counseling interventions for this "compromised caregiver.

- all issues surrounding the caregivers decision to withhold feedings and a specific plan to implement this decision.

- plan to resolve the disagreement between the caregiver and the attending physician with respect to the mother's decision to withhold feedings. Specifically, the admission nurse documented that she spoke to the attending physician after

L 538

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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L 538	<p>Continued From page 35</p> <p>admitting the patient to the hospice to review the plan of care. The admission nurse documented that she informed the attending physician that the mother was going to stop the feedings after the current feeding. The physician stated that he did not agree with the mother's decision and wanted to wait to admit the child to hospice until he spoke to the mother. There was no plan to ensure that these issues were resolved prior to admission. The failure to resolve this conflict and develop an appropriate plan resulted in the restarting, stopping and restarting again of the tube feedings, causing undue pain to the patient and increased caregiver stress.</p> <ul style="list-style-type: none"> <li>- the patient's symptoms related to the withdrawal of artificial nutrition and fluids. Specifically, the comprehensive assessment states that the caregiver stopped the tube feedings after the 3 pm feeding on 06/12/09. There was no plan for the primary nurse to visit the patient to assess any symptoms associated with the withdrawal of feeding and fluids including an assessment of the patient's oral mucosa, skin and pain.</li> <li>- mechanism to assess pain and provide adequate pain management</li> <li>- the patient's neurological status including specific symptoms to report or a plan to assess seizure activity. The comprehensive assessment states that the patient has spastic movements when awake. There is no plan for the primary nurse to assess the patient's seizure activity during visits.</li> <li>- care of the Mickey button (feeding tube). The comprehensive assessment states that as of</li> </ul>	L 538			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  331510		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/29/2009	
NAME OF PROVIDER OR SUPPLIER  HOSPICE AND PALLIATIVE CARE, INC NEW HARTFORD				STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L 538	<p>Continued From page 36</p> <p>06/12/09, the patient was not receiving artificial nutrition or water through the feeding tube. The plan does not include flushing the feeding tube after the administration of pain medications or assessing and cleansing the insertion site of the Mickey button.</p> <p>This record was reviewed with the Director of Nursing and the Executive Director on 09/04/09. No explanation of the above information.</p> <p>2. Patient # 7 was admitted to the hospice on 07/10/09 with terminal diagnoses of ALS and cancer of the larynx. Failure of the hospice to develop a plan of care which addresses the needs identified in the comprehensive assessment has resulted in a plan that is incomplete and does not specify the roles of the primary nurse social worker and other members of the hospice team.</p> <p>The plan of care failed to address the following:</p> <ul style="list-style-type: none"> <li>- skin integrity and wound assessments and management</li> <li>- care of the percutaneous endoscopic gastrostomy (PEG) feeding tube</li> <li>- plan to ensure patient can make needs known</li> <li>- medication management including the administration of pain medication</li> <li>- care of the tracheostomy stoma and respiratory status</li> <li>- specifics related to wound care. The comprehensive assessment completed on 07/13/09 states that the patient has a stage III wound to the coccyx covered with DuoDerm and</li> </ul>	L 538					

NAME OF PROVIDER OR SUPPLIER <b>HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413</b>	
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L 538	<p>Continued From page 37</p> <p>a stage II wound to the left buttocks. The plan of care includes "Calmoseptine to buttocks every 8 hours and DuoDerm to the stage III wound every 3 - 4 days". The plan of care included a nursing visit frequency of every two weeks and does not include an increased frequency for wound care and assessment.</p> <p>- specifics related to assessments of skin integrity. The plan states "assess risk for skin breakdown". The plan states that the patient lays on back most of the day. High risk for breakdown has air mattress in place. The plan does not include the need for assistance with turning and positioning.</p> <p>- care of the PEG feeding tube. The comprehensive assessment stated that the patient requires assistance with tube feedings through the PEG tube. There is no plan to assess the insertion site of the PEG tube; provide care to the skin surrounding the tube; the person responsible for providing Jevity 60 ml/hour and no plan to assess the patient's tolerance of tube feedings by checking for residual.</p> <p>Failure to develop a plan to assess and cleanse the insertion site of the PEG tube has resulted in the patient developing yellow/green drainage requiring the implementation of systemic and topical antibiotic treatment on 07/20/09, 7 days after admission.</p> <p>- administration of medications. The plan of care includes standing orders with an incorrect route of administration. Specifically, Ativan and Roxanol are ordered to be administered by mouth, but the patient is unable to swallow and medications are administered through the feeding</p>	L 538	

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L 538	<p>Continued From page 38 -</p> <p>tube. The plan does not include who will administer the medications and if the feeding tube requires flushing after the medications are administered.</p> <p>- plan to ensure that patient can make needs known. On 07/13/09, the primary nurse documented that the patient doesn't speak and can not move her extremities. The plan of care states that the "primary caregiver uses letter board, patient responds with eye movement". The plan does not specify how the letter board is used. There is also no plan to assess the effectiveness of this communication device.</p> <p>- specifics related to tracheostomy stoma care. The plan of care states "instruct in trach care/maintenance per HPCI policy" On 08/25/09, the surveyor requested a copy of the tracheostomy care policy from the DON. The DON provided the surveyor with the nursing procedure manual on 08/26/09 which lacked a tracheostomy procedure. On 09/25/09, the surveyor again requested copy of policy. The DON provided a copy of a tracheostomy procedure from a "nursing procedure manual". There is no evidence that the interdisciplinary group has approved and adopted this procedure manual.</p> <p>- specifics related to respiratory assessments. The plan of care states "assess respiratory status, sputum and suction as needed, trach". The plan does not include the person responsible for suctioning or parameters for suctioning as needed.</p> <p>- plan to meet personal care needs. The plan of care states "assess home care needs - patient</p>	L 538			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  331510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/29/2009
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L 538	<p>Continued From page 39</p> <p>dependent for all care. Assist primary caregiver with care". The plan does not include how this assistance will be provided by whom and the frequency.</p> <p>There is no plan for the social worker to provide care at a given frequency. Specifically, the social work intervention state "encourage primary caregiver's self care and offer emotional support". There is no frequency for visits or evidence that the patient/family declines social work interventions.</p> <p>This record was reviewed with the Executive Director, Director of Nursing and agency staff on 08/25/09. There was no additional information was provided.</p> <p>3. Patient # 13 was admitted to the hospice on 07/07/09 with a terminal diagnosis of cervical cancer and secondary diagnoses of hypertension, depression, anxiety. Failure of the hospice to develop a comprehensive plan of care has resulted in the patient's unmet safety needs and subsequent fall and subsequent transfer from her home.</p> <p>The plan of care failed to include the following:</p> <ul style="list-style-type: none"> <li>- plan to ensure that patient is safe until an assistive device (wheeled walker) was delivered.</li> <li>- plan to ensure medication compliance and management</li> <li>- plan to ensure that patient's personal care needs are met</li> </ul>	L 538			



STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

331510

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

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10/29/2009

NAME OF PROVIDER OR SUPPLIER

HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD

STREET ADDRESS, CITY, STATE, ZIP CODE

4277 MIDDLE SETTLEMENT ROAD

NEW HARTFORD, NY 13413

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COMPLETION  
DATE

L 538

Continued From page 40  
Specifically,

- plan of care states educate patient/primary caregiver on fall prevention measures, lives on second floor apartment. The plan of care does not include a plan to assess the patient more frequently than every 2 weeks to ensure safe ambulation. Failure to develop a plan to ensure that the patient is safe from falls resulted in a patient fall on 07/10/09 prior to the delivery of her wheeled walker.

- plan to supervise medication administration and assess compliance. The comprehensive assessment states that the patient is forgetful and that hospice staff will provide medication set-up. There is no plan for the hospice nurse to assess medication compliance even after the admission nurse documented that the patient was not taking her medication for angina/blood pressure. The plan of care does not include medication set-up by the hospice, the patient or the family.

Failure to develop a plan to ensure that the patient is taking her medication as ordered resulted medication non-compliance placing the patient at risk for high blood pressure, increased anxiety and depression. The patient was reluctantly transferred to the hospice residence on 09/01/09 due to her inability to manage her medications and increased symptoms of depression and hypertension.

- plan to ensure that patient's nutritional needs can be met at home. Specifically, the comprehensive assessment states that the patient eats at her boyfriend's apartment. The plan of care states that the nurse is to "assess nutritional status and tolerance and assess

L 538

NAME OF PROVIDER OR SUPPLIER

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STREET ADDRESS, CITY, STATE, ZIP CODE

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NEW HARTFORD, NY 13413.

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L 538	Continued From page 41 dietary; activity factors". The plan does not include an explanation of "assess dietary; activity factors" or how the patient gets to the boyfriend's apartment to eat.  This record was reviewed with the DON and Executive Director on 09/10/09. There was no process in place to identify that the patient was a safety risk related to medication supervision. Although the IDG discussed the patient's need for a medication box, there was no plan developed for the primary nurse to increase the frequency of visits to ensure safe administration of medications. During the 09/10/09 interview with the DON and patient case manager (PCM), the PCM stated that the responsibility for the patient's medication was left to the patient's daughter.	L538	<b>§ 418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES</b> Please refer to L536 # 1 Revision of following policies: <ul style="list-style-type: none"> <li>• Coordination of Services</li> <li>• Documentation Requirements</li> <li>• Interdisciplinary Group</li> <li>• Nursing Services</li> <li>• Pain and Symptom Management</li> <li>• Physician Services</li> <li>• Plan of Care-Content</li> <li>• Plan of Care</li> <li>• Professional Management</li> </ul>	Approved by Governor Body: 11/16/09  Education provided to staff: 11/17/09
L 539	418.56(a)(1) APPROACH TO SERVICE DELIVERY  (1) The hospice must designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services.  This STANDARD is not met as evidenced by: Based on review of 14 clinical records, policy and procedures and interviews with the Director of Nursing, Executive Director, members of the interdisciplinary group (IDG) and agency staff, there is a lack of evidence in 14 records that the interdisciplinary group supervises the care and services to meet the needs of the patient and	L539	<b>§ 418.56 (a)(1) APPROACH TO SERVICE DELIVERY</b> Please refer to L536 # 1 and 2 and 3 Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services <ul style="list-style-type: none"> <li>• Comprehensive Assessment completed by IDG by day 5 of hospice services</li> <li>• Interdisciplinary review of plan of care completed at IDG and documented on IDG minutes</li> <li>• Appropriate updates made to Plan of care</li> <li>• Implementation of new forms: <ul style="list-style-type: none"> <li>o Hospice Plan of Care form CL.255</li> <li>o IDG Review and update to Hospice Plan of Care form CL275</li> <li>o Hospice Plan of Care Change form CL.255a</li> </ul> </li> </ul>	Implement ation 11/20/09

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L 539	<p>Continued From page 42 family. Patients # 1 - 14.</p> <p>Failure of the IDG to provide adequate supervision of care and services has resulted in the negative outcomes for patients # 1, 8, 13, and the potential for negative outcomes for the agency's entire patient population.</p> <p>1. Patient # 8, a [REDACTED] was admitted to the hospice on 06/12/09 with a diagnosis of unspecified debility resulting from mitochondrial depletion syndrome. The IDG failed to develop, implement and supervise a coordinated plan of care that meets the physical needs of the patient and the psychosocial needs of the caregiver.</p> <p>There is a lack of evidence that the IDG was involved in the decision to admit this [REDACTED] to hospice after the attending physician voiced objections and disagreement with the admission and plan of care.</p> <p>Additionally, at the time of admission, there was a lack of communication and care planning to ensure that the needs of the overwhelmed caregiver and terminally ill child were met which resulted in increased caregiver stress and unmanaged pain for the child.</p> <p>Specifically,</p> <p>The admission nurse admitted the patient and completed the initial assessment on 06/12/09. During the assessment, the nurse observed the mother administering the patient's tube feeding through the Mickey button. The nurse documented that the patient was "uncomfortable" during the feeding and that the mother informed the nurse that she was going to discontinue</p>	L 539			

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L 539	<p>Continued From page 43</p> <p>feedings and medications after the 3 pm feeding.</p> <p>The admission nurse documented that she left the patient's home and contacted the attending physician. She documented that she "told him of mom's decision to stop tube feedings and medications, he was quite angry that she was going to do this and says that he does not agree with this. Maybe we should wait for admission so he can talk to the mother." However, the nurse had already admitted the patient.</p> <p>There was no evidence the admission nurse discussed the physician's objection to admission with the members of the hospice team including the patient case manager and the patient's mother. The admission nurse documented that she contacted a hospice medical director who agreed with the mother's decision to stop feedings. There was no evidence of a team process to evaluate the appropriateness for admission to the hospice and no resolve to the attending physician's objections to the plan of care.</p> <p>As a result of this failure to discuss the appropriateness for admission with the hospice team, the IDG failed to develop a consistent plan of care. The patient was subjected to the team's eventual decision to re-start tube feedings on 06/17/09 due largely to the attending physician's disagreement with the hospice plan of care. Feeding had been discontinued by the mother on 06/12/09, because of the patient's uncontrolled pain with feedings.</p> <p>It was not until 3 days after admission that the hospice conducted an interdisciplinary group (IDG) meeting. The meeting minutes dated</p>	L 539			

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L 539	<p>Continued From page 44</p> <p>6/15/09, failed to include a discussion of the attending physician's disagreement with the mother's plan to discontinue feedings and his wish to delay admission to hospice. Although the plan of care developed by the IDG included withholding of feedings, there were no specific interventions for implementing this plan, such as administration of water and provision of mouth care. The plan of care also did not include a visit frequency for nursing or social work. The IDG was attended by all members of the team including the patient case manager, the admission nurse, primary nurse and the medical director.</p> <p>On 06/15/09, at 4:45 pm, the hospice on-call nurse documented "received a call from the primary caregiver stating that the attending physician called her and was angry that she had stopped the feedings". The mother stated that the physician said that he would "seek legal guardian for the baby". The mother informed the hospice nurse how angry and upset she was at the physician.</p> <p>The on-call nurse conducted a home visit at 5 pm. The nurse documented that the child was not in any distress, lying in crib moving arms and legs "with continuous tremor like activity", mouth dry, tongue with "furr" appearance. Mother states she has not provided any moisture or swabbing of mouth to keep moist. The on-call nurse failed to discuss or explore emotional status of primary caregiver except the documentation that "she (the caregiver) is tired of the whole situation". There was no team discussion until the next day on 06/16/09 at 10:30 am during a "special IDG meeting".</p>	L 539					

## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

OMB NO. 0938-0002

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L 539	<p>Continued From page 45.</p> <p>The minutes of the special IDG meeting held on 06/16/09, at 10:30 am, stated that the meeting was held because of the pediatrician's call to the mother on 06/15/09, regarding his concerns about the mother stopping the tube feedings. The meeting minutes stated "The mother upset, seeking support for her decision". The plan documented on the "special IDG meeting form" was: discuss issues with the medical director; social worker to talk to the mother, and the primary nurse to assess the patient. The plan failed to include interventions to address the mother's concerns or the questionable admission to the hospice.</p> <p>The primary nurse assessed the patient on 6/16/09 after the IDG meeting and documented that the patient sleeping quietly in mother's arms, that the mother was weepy and that the mother continued to have cramping from the miscarriage. There was no evidence of communication with the hospice team regarding the physical condition and emotional state of the mother.</p> <p>On 06/17/09, the patient case manager documented at 10:45 am, she received a phone call from the medical director who stated that he "reviewed the goals of care with the attending physician and agrees that we need to resume tube feeding at this time". The caregiver was not included in this decision and the Patient Case Manager (PCM) documented that the social worker and primary nurse "will call to let ... mother know about plan to resume feedings". There was no involvement of the mother in the decision to restart feedings.</p> <p>This failure to communicate and involve the mother in the decision making process caused</p>	L 539			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-039

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L 539	<p>Continued From page 46</p> <p>the mother undue stress as follows:</p> <p>The clinical record contained documentation that at 11 am, on 06/17/09, the social worker and primary nurse called the caregiver to inform her of the hospice's decision to restart the feedings. The primary nurse documented that the caregiver was "very upset, verbalized feelings regarding conflicting information." The nurse also documented that the caregiver informed them (the nurse and social worker) that she was so upset that she could not speak to them right now. There was no discussion with the rest of the team regarding the mothers "feelings"</p> <p>Although the PCM obtained orders from the hospice medical director to initiate feedings, there were no parameters to assess tolerance including checking for residual tube feedings.</p> <p>On 06/17/09, the primary nurse documented that at 1 pm she visited the patient. During the visit, mother informed the nurse that she had given the child 20 ml of formula with 60 ml of water. The primary nurse stated that the patient was lying on her back having no distress and that licensed practical nurses will assist and monitor feedings beginning at 5 pm. There was no plan to check residual feedings and no plan to flush the feeding tube after the feedings were completed.</p> <p>Additionally, the primary nurse documented that at 3 pm, child protective services and police visited the patient. The primary nurse documented that the "mom was at first quite angry" The primary nurse discussed the visit with the social worker however, there is no evidence that the team was made aware of the child protective services visit and the mother's anger</p>	L 539			

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L 539	<p>Continued From page 47 regarding this.</p> <p>On 06/17/09 at 6:30 pm, the LPN documented that she attempted to administer the tube feedings, the child immediately began "tensing legs, pulling knees to chest with the administration of water prior to feeding formula". The LPN documented that she contacted the patient case manager who directed the LPN to attempt the feeding again 2 hours later. At 8:30 pm the LPN documented that she attempted the feedings again slowly and the patient tolerated the feeding. The next feeding was given by a different LPN at 2:30 in the morning over 40 minutes and the LPN documented that the patient began to fuss and cry when completed. The LPN did not report this crying and fussing to the team or the case manager and did not associate the crying with intolerance of tube feedings.</p> <p>On 06/18/09, at 8:30 am, the same LPN documented that she attempted feedings, the patient did not tolerate them and as of 10:00 am, stated that the child was still crying. Additionally, on 06/18/09, an IDG meeting was held in which the primary nurse documented that the child was tolerating the feedings. The primary nurse was unaware of the patient's intolerance of feedings until 12:30 pm.</p> <p>On 06/18/09, at 12:30 pm, the PCM documented that she discussed the findings of the LPN's visit from 06/18/09 with the medical director and informed him that the child did not tolerate the feedings. The patient case manager documented that the medical director and attending agreed to discontinue the feedings. The primary nurse documented that she informed the caregiver of the decision to stop feedings, the primary nurse</p>	L 539			



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L 539	<p>Continued From page 48</p> <p>documented "she request written note to that effect." The IDG failed to develop a plan for the withholding of feedings once again. The primary nurse failed to assess the mother's emotional state regarding the hospice's indecisiveness and failure to support her decision to discontinue feedings.</p> <p>On 06/24/09, the primary nurse documented that she received a call from the LPN stating that the patient had a hunger cry and that she gave him 15 cc of water. The primary nurse documented that she visited the patient at 12:30 pm. that day and documented child "looks comfortable. There was no assessment of the LPN's observations of "hunger cries."</p> <p>On 06/27/09, the LPN visited the patient at 3:15 pm and documented that the child was "opening his mouth, rooting, placing hand in mouth, eyes open and moving, occasional cry". There was no RN visit to assess these symptoms. The on-call nurse documented that she received a call from the LPN stating that the LPN made a decision to administer 15 cc of water, which was in direct conflict to the latest directive from the IDG to withhold feelings and as soon as she gave him the water, he became active kicking his legs and arm. The on call nurse documented "LPN felt he was active; not in pain" The on-call nurse failed to make a visit to assess the patient to determine if the patient was in pain. There was no team discussion regarding the unauthorized actions acclaims of the LPN until 06/29/09, 24 hours later.</p> <p>On 06/29/09, a special IDG meeting was held to discuss the LPN's "concern that the baby is exhibiting rooting behavior-questions need for</p>	L 539		

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NAME OF PROVIDER OR SUPPLIER  HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413		
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L 539	<p>Continued From page 49</p> <p>tube feeding and or fluid via g-tube - does not feel baby is comfortable without any fluids" The "IDG agreed to try giving H2O 15 ml per G-tube every 4 hours slowly". This decision was made solely based on the observations of a LPN without a Registered Nurse performing a professional assessment of the patient's behavior. Again the decision to restart the administration of water and feedings if tolerated were done with out consulting the mother.</p> <p>On 06/29/09, primary nurse instructed the LPN to administer feedings and to keep the primary nurse updated. The LPN visited the patient and at 4 pm, the nurse attempted to administer 15 cc water, the patient was unable to tolerate, observed abdominal pain. There was no team process in place to ensure that the patient was not subjected to treatment that caused an increase in pain based on an opinion of an LPN without an assessment by a Registered Nurse.</p> <p>On 09/04/09 the surveyor interviewed the LPN who reported the rooting and hunger cry on 6/24/09 and 6/27/09. The surveyor asked the LPN to discuss the child's pain. The LPN stated that the child would "cry for help... bring knees to chest". The surveyor asked the LPN if she ever spoke to the primary nurse regarding the patient's condition. She stated that she mostly worked nights so she did not speak to the primary nurse or the rest of the hospice team.</p> <p>This record was reviewed with the Director of Nursing, PCM and the Executive Director on 09/04/09. PCM stated that this was a very difficult case, however, there was no further information provided regarding the failure of the IDG to supervise the plan of care and ensure that</p>	L 539			

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:  331510		A. BUILDING _____ B. WING _____		COMPLETED  C 10/29/2009	
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L 539	<p>Continued From page 50</p> <p>the needs of the patient and caregiver were met.</p> <p>2. Patient # 1 was admitted to the hospice on 04/22/09 with a diagnosis of lung cancer and metastasis to the brain. The IDG conducted every two week meetings to provide oversight of patient care and services. There was no evidence that the team was fully aware of the patient's deteriorating pressure ulcer, increased pain in the coccyx region and failed to provide guidance to the team. Additionally, the primary nurse was using wound measurements that were inconsistent with agency policies and the IDG team did not clarify these measurements.</p> <p>Specifically, the patient developed a pressure ulcer to the coccyx on 07/08/09 measuring 1.5 "cm2" described as a small superficial area. On 07/10/09, the primary nurse visited the patient to deliver supplies. The nurse documented that the patient had complaints of discomfort when sitting in the kitchen chair. The nurse documented that she brought a "donut cushion" for him to use. The primary nurse failed to assess the patient's buttocks area where he expressed pain when sitting and had an open wound identified on 07/08/09.</p> <p>An IDG meeting was held on 07/09/09, and there is no evidence that the team discussed the need for the primary nurse to observe the patient's wound more frequently than every 2 weeks or developed a plan to alleviate pressure and prevent further wound deterioration.</p> <p>On 07/17/09 and 07/22/09, the primary nurse documented that the patient's wound was now smaller, measuring 1 "cm2". The hospice nurse documented that the caregiver is applying</p>	L 539					

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L 539	<p>Continued From page 51</p> <p>Remedy cream to the open area not the gauze, although this was not included in the hospice plan of care.</p> <p>The IDG meeting minutes completed on 07/23/09 contain conflicting information regarding the status of the wound. The minutes state "decubitus ulcer improved and changed to barrier cream only due tape abrasions. Decubitus worsened and bordered gauze resumed". There is no documentation that the wound had deteriorated. There was no discussion with the team of a plan to ensure that the patient had pressure relieving devices.</p> <p>By 08/05/09, the primary nurse documented that the patient's wound was a stage II, was 4 "cm2" with moderate tan drainage, wound edge red, wound bed black and white with a depth described as "slightly more than superficial" and that the patient had pain intensity of 8 on a scale of 0 to 10. The hospice nurse documented that the wound care was changed from Remedy ointment to Tender Wet Active. The hospice nurse documented that she contacted the attending physician, however there is no communication with the team to discuss the new wound care and further guidance regarding this wound.</p> <p>An IDG meeting was conducted on 08/06/09, the meeting minutes stated that the patient had increased pain and "decubitus on sacrum has necrotic tissue change to tender wet active dressing". There was no discussion of the fact that the pressure ulcer was deteriorating or that the patient's increased pain was located in the coccyx region where the pressure ulcer is located. There was also no guidance to the</p>	L 539			

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L 539	<p>Continued From page 52</p> <p>primary nurse from the team regarding the need for pressure relieving devices and/or increases in nursing visits to assess the condition of this wound.</p> <p>Although the hospice nurse developed a plan to change the wound care, there was no visit completed until two days later. On 08/07/09, the nurse made a visit but failed to assess the condition of the wound and failed to assess the patient's pain/pain management.</p> <p>On 08/09/09, the on-call nurse documented that she visited the patient after receiving a call from the patient's caregiver that the patient was unable to swallow his medication. The on-call nurse documented that the patient was complaining of a pain level of 8 on a scale of 0-10 in his coccyx region. Without assessing the coccyx region, the location of the pain, the nurse proceeded to access the portacath and start a morphine drip for pain. There is no evidence that the on-call nurse was aware that the patient had a decubitus ulcer or attempted to observe the area where severe pain was noted.</p> <p>On 08/10/09, the primary nurse again failed to assess the patient's wound, failed to assess caregiver competency in providing daily wound care, and failed to assess the patient's pain. The nurse documented that the caregiver stated that the patient was "crying out when she moved him during his bath." The primary nurse failed to assess the patient's current pain level. There was no subsequent assessment visit completed for two days, until 08/12/09.</p> <p>On 08/12/09 the hospice nurse again failed to recognize that the patient's increased pain and</p>	L 539			

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L 539	<p>Continued From page 53</p> <p>agitation is related to the deteriorating coccyx wound. Specifically, the primary nurse documented the following wound assessment: "stage III measuring 15 "cm2", with a large amount of tan/brown drainage, a black necrotic wound bed that is full thickness". The wound measurement represents a deterioration of the wound and increase in surface size of 9 "cm2" in 7 days. The primary nurse documented that the patient was "rigid and tense with his head tipped back, eyes open and staring at the ceiling". The patient's wife informed the hospice nurse that he was having periods of agitation where he was in the bed "on his hands and knees". The nurse failed to rate the patient's pain or determine if the behavior was related to his pain. The primary nurse failed to discuss the patient's pain and deteriorating wound with the hospice team.</p> <p>The hospice nurse visited the patient on 08/13, 14, 17, and 19/09. During these visits, the hospice nurse failed to observe and assess the coccyx pressure ulcer. An IDG meeting was completed on 08/20/09. The meeting minutes stated that the "sacral decubitus worsening dressings changed to manage exudate." There was no discussion of the primary nurse's failure to assess the condition of the deteriorating wound since 08/12/09 and failure to assess the patient's pain. There was also no plan to provide the patient with any type of pressure relieving devices, increased nursing assessment visits, or effective pain management</p> <p>When the nurse finally assessed the patient's pressure ulcer 9 days later on 08/21/09, the coccyx wound measured 35 "cm2" and the nurse documented that the patient now has multiple pressure areas including left ankle, and bilateral</p>	L 539		

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L 539	<p>Continued From page 54</p> <p>hips.</p> <p>On 08/25/09, the surveyor interviewed the Director of Nursing (DON), who was also fulfilling the role of patient case manager, and the Executive Director regarding the above issues. The surveyor asked the DON if she reviewed the medical record prior to the IDG meetings to identify significant issues for discussion during the IDG meetings. The DON stated that she does not review the record and relies on communication from the primary nurse.</p> <p>On 08/26/09 at 12:00 pm, the surveyor interviewed the primary nurse, at the interview was the DON and the Executive Director. The surveyor asked the hospice nurse how she communicated changes in the patient's condition with to the DON and the rest of the hospice team. The nurse stated that she usually calls the DON and either leaves a voice mail or has a conversation with her. The primary nurse stated voice mail is how communication usually takes place with the rest of the team. The surveyor asked the primary nurse where this communication was documented. The nurse stated that she documents it in her assessment note, however, there was no documented evidence that this communication occurred.</p> <p>3. Patient # 13 was admitted to the hospice on 07/07/09 with a primary diagnosis of cancer of the cervix and secondary diagnoses of depression, anxiety, and acute renal failure. The patient lives alone in an apartment. There was a lack of communication between with the hospice team regarding medication management, falls prevention and personal care.</p>	L 539			

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L 539	<p>Continued From page 55</p> <p>Failure to ensure an adequate team process is in place has resulted in the patient's inability to remain in her own home.</p> <p>Specifically, the initial and comprehensive assessments completed on 07/07 and 07/08/09 respectively indicate that the patient was forgetful, lived alone, had an unsteady gait and was awaiting delivery of a wheeled walker for ambulation safety on 07/10/09. The hospice failed to ensure that the patient was safe. The patient subsequently fell on 07/10/09 and hit her nose as reported to the nurse by the volunteer coordinator.</p> <p>There is no evidence that the IDG was aware of the patient's fall, and was consulted to provide oversight and to ensure that adequate assessments were provided by the primary nurse or any other members of the hospice team.</p> <p>The primary nurse failed to contact the patient to schedule a visit to assess any injuries that may have occurred as a result of the fall.</p> <p>On 07/13/09, the social worker called the patient's daughter and documented that the patient was staying at the daughters home for a few days after the fall. The social worker documented that he reported this information to the primary nurse on 07/13/09. There was no follow-up contact with the patient until 07/16/09.</p> <p>The first IDG meeting was completed on 07/16/09. The meeting minutes stated that the patient had a fall on 07/10/09, but there was no discussion of a plan to ensure that the patient did not have a subsequent fall. The IDG minutes also stated that the patient would accept a</p>	L 539		



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L 539	<p>Continued From page 56</p> <p>medication minder, however, the team did not express how the medication would be set up or how the primary nurse would evaluate compliance with medications. The plan of care indicated that the hospice nurse was only going to visit the patient once every 2 weeks, there was no team discussion regarding the appropriateness of this plan.</p> <p>On 07/16/09, the primary nurse documented that she contacted the patient's daughter and she stated that the patient was still at the daughter's home and has had no further falls. There was no communication with the team regarding the primary nurse's failure to visit the patient and no discussion of how the patient will remain safe when she returns to her own apartment. The primary nurse failed to visit the patient or discuss a plan to ensure patient safety prior the the patient returning to her own apartment alone.</p> <p>On 07/22/09, the hospice nurse documented that she visited the patient at her home. The nurse failed to ensure that the patient remained safe in her own home. Specifically, the hospice nurse failed to assess the following:</p> <ul style="list-style-type: none"> <li>- patient's ability to use the wheeled walker in the home</li> <li>- compliance with medication administration. The patient states that she does not want a medication box, however, the nurse failed assess and develop a plan to ensure that the patient takes her medication as ordered including her anti-angina/blood pressure medication.</li> <li>- an assessment of her nutritional status including further investigation of how patient</li> </ul>	L 539			

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L 539	<p>Continued From page 57</p> <p>obtains her meals. The primary nurse documented that the patient eats at her boyfriend's apartment, but there is no discussion of how the patient gets to her boyfriends and no plan to ensure that she is able to get there safely.</p> <ul style="list-style-type: none"> <li>- an assessment of the patient's ability to provide personal care. Specifically, the primary nurse documented that the patient's apartment has a strong odor of urine. The nurse did not document if the patient also smelled like urine, if she was incontinent or unable to ambulate to the bathroom.</li> <li>- an assessment of the amount of assistance if any that the patient's daughter is willing and able to provide for the patient. There was no discussion with the patient care manager to review the status of the patient and no plan to increase nursing visits to ensure the patient's needs are met.</li> </ul> <p>There was no evidence in the 07/30/09 IDG meeting minutes that the hospice team was aware of the nurse's failure to assess the above concerns. The only issue documented as discussed was that the patient did not want the hospice to set up the medications however, there was no discussion of the patient's medication compliance, nutritional status, ability to provide personal care or the amount of assistance that the caregiver is willing and able to provide.</p> <p>There was no primary nursing visit completed until 08/07/09, 16 days later. During the visit the primary nurse failed to assess the patient's use of the walker, overall medication compliance, even after the patient stated that she could not remember if she used her inhalers. The hospice</p>	L 539			

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L 539	<p>Continued From page 58</p> <p>nurse documented that the patient was agreeable to have daughter set up medications, however, there was no assessment of the daughters willingness or availability to perform this task.</p> <p>Upon arrival on 08/07/09, the primary nurse documented that the patient was not dressed. The nurse failed to assess if the patient was showered or bathed and if the primary nurse assisted the patient with dressing during the visit. The primary nurse failed to assess the patient's nutritional status and states that the patient vomited yesterday, "states she eats junk food" as an explanation for why she vomited. There was no reference to the patient eating at the boyfriend's and no assessment of how the patient obtains her food. The nurse documented that the patient agreed to a home health aide twice a week. There was no communication with the team to discuss the patient's declining status and inability to perform self care.</p> <p>The IDG meeting was completed on 08/13/09, the meeting minutes stated that the daughter was setting up the medications there was no discussion of the daughter's willingness or availability to set up medications. Additionally, there was no discussion of the patient's medication compliance and no discussion of the patient's nutritional status. The meeting minutes did indicate that home health aide care was provided twice a week, however, there is no assessment of whether the patient is receptive to having a home health aide, and no plan for the nurse to visit the patient to assess the patient's ongoing medication compliance and ability to provide personal care.</p> <p>There was no patient assessment until 11 days</p>	L 539			

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L 539	<p>Continued From page 59</p> <p>later on 08/18/09. The primary nurse documented that the patient forgot her medications, but failed to assess the specific medications she did not take, failed to assess how many doses of each medication she failed to take, and failed to notify Patient Case Manager. There was no discussion with the patient regarding a plan to ensure medication compliance. The primary nurse also documented that there was a strong smell of urine in the home however, did not assess if the smell was from the patient or from her apartment. The nurse failed to assess the patient's nutritional status including the ability to obtain food or if the patient continues to eat meals at the boyfriend's apartment. The primary nurse failed to recognize that the patient required an increase in supervision of medications, meals and personal care and subsequently failed to visit the patient until 14 days later.</p> <p>Also, there was also no communication with the IDG to discuss the patient's medication noncompliance or the cleanliness of the patient and the patient's apartment.</p> <p>On 08/24/09, the social worker visited the patient and identified that the patient was "disheveled, had not bathed in some time, and was not taking her medications. The social worker discussed this with the primary nurse however, there was no discussion of the rest of the team to evaluate the patient's need for subsequent visits and to ensure additional services to ensure medication compliance and patient safety.</p> <p>On 08/31/09, a special IDG meeting was completed. The meeting minutes stated that the patient is encouraged to move to the hospice</p>	L 539	

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L 539	<p>Continued From page 60</p> <p>center. The team also stated that if the patient won't move she should have lifeline and meals on wheels. The team states that the medications are setup by the primary caregiver, and the home health aide will remind. However, the plan of care only includes a home health aide 2 times a week, and there was no discussion of how the patient's needs will be met the other 5 days a week.</p> <p>On 08/31/09, the social worker visited the patient and again the social worker documented that the patient was still lying in bed at 1:15 pm. The social worker asked the patient if she had eaten. She stated that she had eaten earlier in the day but she was hungry. The social worker found food in the refrigerator which she heated up. The social worker also documented that she was concerned that the patient was depressed, not eating well and not taking her medication and not receiving adequate care to assure her well being. The social worker contacted the Patient Care Manager however, there was no discussion with the primary nurse or the rest of the hospice team including the medical director.</p> <p>On 09/01/09, the primary nurse and the social worker visited the patient and again identified that the patient did not take her medication, which included her anti-hypertension medication. The nurse documented that the patient's blood pressure was elevated to 150/100, there were saturated adult diapers on the floor, and no food in her apartment. Based on this assessment and the social worker assessment of 08/31/09, the IDG decided that the patient should be transferred to the hospice residence.</p> <p>The lack of a team process resulted in the patient being displaced from her home. The IDG failed</p>	L 539			

NAME OF PROVIDER OR SUPPLIER <b>HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
L 539	Continued From page 61 to address the patient's needs and failed to develop interventions which may have allowed the patient to remain in her own home.  On 09/02/09, the surveyor visited the patient at the hospice residence. The patient stated that she did not want to move from her home, and her cat. The primary nurse and social worker failed to update comprehensive assessments to address the potential need for increased nursing visits to ensure patient safety, personal care, and medication management.  This record was reviewed with the DON, Executive Director and the patient case manager on 09/10/09. The patient case manager stated that she believed that the patient's daughter was managing the patient's medications however, there was no assessment of the daughters availability or willingness to provide assistance. There was no explanation regarding the other nursing issues.		
L-540	418.56(a)(1) APPROACH TO SERVICE DELIVERY  The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care.  This STANDARD is not met as evidenced by: Based on a review of 14 clinical records and interviews with the Director of Nursing, Executive Director and agency staff, there is a lack of evidence in 14 records that a registered nurse (RN) designated as coordinator ensures that	L540	<p>§ 418.56(a) APPROACH TO SERVICE DELIVERY</p> <p>Please see corrective actions detailed at L534, L533, L535, L539 and L591. In addition, the following corrective actions have been implemented:</p> <ol style="list-style-type: none"> <li>1. The Human Resources Department is recruiting for additional Clinical and administrative positions to support revised organizational structure. <span style="float: right;">Initiated 10/19/09 and Ongoing</span></li> <li>2. Each patient will be assigned an RN Primary Nurse to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. <span style="float: right;">Implement ed 11/20/09</span></li> </ol>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 331510		A. BUILDING _____ B. WING _____		C 10/29/2009	
NAME OF PROVIDER OR SUPPLIER HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD				STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
L 540	<p>Continued From page 62</p> <p>coordination, assessment, and implementation of the plan of care is provided. Patients # 1 - 14</p> <p>Failure to ensure that coordination, assessment and implementation of the plan of care is provided to patients by the RN coordinator has resulted in negative outcomes patients #1, 7, 8, 13 and the potential for negative outcomes for the entire agency population.</p> <p>Specifically, the agency has assigned two registered nurse coordinators responsible for ensuring patient care needs are met. During an interview with the Director of Nursing and Executive Director on 08/24/09, the surveyor asked who was assigned the role of RN coordinator.</p> <p>The Executive Director stated that the role of RN coordinator was split between two experienced registered nurses and the position is titled "Patient Case Manager (PCM)". The Executive Director further explained that one of the PCMs was on leave from the agency and that position is being filled by the DON. There is however, no evidence that the PCMs are ensuring that coordination of care and services is being provided.</p> <p>In 14 clinical records reviewed, there is no evidence that the patient care managers are ensuring that:</p> <ul style="list-style-type: none"> <li>- comprehensive assessments are complete and accurately reflect the current status of the patient</li> <li>- changes in the comprehensive assessment are communicated to the hospice interdisciplinary group (IDG) and recommendations for care are</li> </ul>	L 540	<p>3. The <del>Manager</del> of Clinical Services/Clinical Supervisor will maintain oversight and attend IDG meetings.</p> <p>4. Implementation of Policy PC.C45: Coordination of Services which includes: <del>Director</del></p> <ul style="list-style-type: none"> <li>• Manager of Clinical Services assumes overall responsibility for ensuring there are effective methods of communication that allow for the coordination of the care and services provided by the IDG</li> <li>• Coordination of services and continuity of care is facilitated by established formal and informal communication mechanisms between all disciplines providing care: <ul style="list-style-type: none"> <li>• IDG meetings</li> <li>• Ad hoc case conferences when needed</li> <li>• Family meetings as appropriate</li> <li>• Discharge and/or transfer summaries as needed</li> <li>• Telephone communications and voice mail; and</li> <li>• Report from and to on-call staff.</li> </ul> </li> </ul>			Implement ed: 11/11/09	Implement ed: 11/20/09

11/20/09 acceptable Paulof Williams M

5. IDG minutes will be reviewed as a component of the monthly chart audit of 10% of the ADC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER IDENTIFICATION NUMBER: 331510		A. BUILDING _____ B. WING _____		COMPLETED C 10/29/2009	
NAME OF PROVIDER OR SUPPLIER HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD				STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
L 540	Continued From page 63 discussed with all persons responsible for providing that care.  - the plan of care is updated and meets the needs of the patient to ensure negative outcomes are avoided.  - the PCM is aware of the current status of the patient through on-going review of clinical record reviews as outlined in the plan of correction to the 12/02/08 survey.  Each clinical record was reviewed with the patient case managers/Director of Nursing and the Executive Director throughout the survey. The Director of Nursing stated during an interview with the surveyor on 08/26/09, that she does not review the clinical record prior to the IDG meeting to determine if the plan of care is followed and/or meets the needs of the patient and family.			L 540			
L 548	See L534, L533, L535, L539 418.56(c)(3) CONTENT OF PLAN OF CARE  [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care.  This STANDARD is not met as evidenced by: Based on a review of 14 clinical records, policies and procedures and interviews with the Director of Nursing (DON) and the Executive Director, there is no evidence in 14 records (100%) that plans of care include measurable outcomes anticipated from implementing and coordinating			L548	§ 418.56(c)(3) CONTENT OF PLAN OF CARE Please refer to L536 # 3 (c and d) 1. A Performance Improvement Project was initiated to review all tools and forms related to care planning. 2. Based on the review of the forms and tools, a new plan of care tool and related care planning forms are being phased in. The new tools are in compliance with hospice regulations. 3. Education on the new tools will be provided to staff 12/1/09. 4. Staff will use new tools with all new admissions as of 12/08/09. 5. All current patients will have their plans of care updated with the new tools by 1/1/10.		64 of

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*6 additional  
monitoring  
100% POC review will occur concurrently  
with the 100% audit of initial + comprehensive  
assessments. In addition the POC will be  
audited as a component of the  
10% ADC audited monthly.*

*11/30/09 acceptable Paul J. [signature]*



NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD

4277 MIDDLE SETTLEMENT ROAD  
NEW HARTFORD, NY 13413(X4) ID  
PREFIX  
TAGSUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)ID  
PREFIX  
TAGPROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)(X5)  
COMPLETION  
DATE

L 548

Continued From page 64  
the plan of care. Patients # 1 - 14.

L 548

Failure to incorporate measurable Outcomes in the plan of care gives the agency no mechanism to determine if interventions identified have been effective in pain and symptom management.

The plans of care for each patient contain goals which are not measurable. The goals are very generic and contain general statements such as: "optimal cardiac function; optimal respiratory function/decrease or control dyspnea".

The surveyor interviewed the DON on 09/11/09 and asked her if the agency developed measurable outcomes based on the interventions identified. The DON stated that they did not have specific measurable outcomes.

L 553 418.56(d) REVIEW OF THE PLAN OF CARE

A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care.

This STANDARD is not met as evidenced by: Based on a review of 14 clinical records, policies and procedures and interviews with the Director of Nursing (DON) and the Executive Director, there is no evidence in 14 records (100%) that revised plans of care include information from the updated comprehensive assessments and notes the patient's progress toward outcomes and goals specified in the plan of care. Patients # 1 - 14.

Failure of the agency to include information from the updated comprehensive assessments and

L553

11/30/09 acceptable  
Dyckman

## § 418.56(d) REVIEW OF THE PLAN OF CARE

Please refer to L536 # 3 (c, d and e)

- Initiate Nursing Assessment, Psychosocial Assessment, Spiritual Assessment update forms

Completed  
11/20/09

- Initiate IDG Review and Update to the plan of care forms

Completed  
12/4/09

- Initiate data collection that quantifies meeting of patient outcomes

Initiated  
12/4/09

- ~~Manager~~ of Clinical Services/Clinical Supervisor will Review discrepancies from Plan of Care and expected outcomes.

Ongoing

Discrepancies will be communicated to the Interim Executive Director and the QAPI committee.

monitoring see L 548  
#6

NAME OF PROVIDER OR SUPPLIER

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HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD

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NEW HARTFORD, NY 13413

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 553	Continued From page 65 progress toward outcomes and goals has the potential for unmet patient needs.  Specifically, each clinical record reviewed contained current plans of care. The plans of care lacked evidence of measurable outcomes therefore, revised plans of care do not include the patient's progress toward outcomes and goals.  Each clinical record was reviewed with the DON and Executive Director throughout the survey and this information was discussed. The DON during an interview on 09/11/09, confirmed that the plans of care do not have measurable outcomes and do not document progress toward goal on the plans of care.	L 553		
L 559	418.58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT  This CONDITION is not met as evidenced by: o Failure of the hospice to develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program that reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. See L560, L561  o Failure to ensure a quality management system that is able to measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that	L559 and L560  11/30/09 acceptable  Paula Williams	ONGOING  § 418.58 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT To ensure the hospice develops, implements, and maintains an effective, ongoing, hospice-wide, data-driven QAPI program that reflects the complexity of the organization and its services and focuses on indicators related to improved palliative outcomes and takes actions to demonstrate improvement in hospice performance, the following corrective measures will be completed by the date specified: <i>Executive Director</i> 1. The Interim <del>Administrator</del> and the hospice's QAPI Committee will ensure that the hospice's QAPI program provides for measurable improvement in indicators related to palliative outcomes and hospice services. This will be evidenced by: <ul style="list-style-type: none"> <li>The identification of quality indicators that assess hospice services, operations and processes of care;</li> <li>Collection of data related to the selected quality indicators; and</li> <li>Analysis of the data to</li> </ul>	Implement ed 11/20/09  Completi n date: 12/4/09 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION		B. WING		10/29/2009	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD		4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
L 559	Continued From page 66 enable the hospice to assess processes of care, hospice services, and operations See L562  o Failure to ensure that the data collected is used to monitor the effectiveness and safety of services and quality; identifies opportunities and priorities for improvement. See L564  o Failure to ensure that the governing body approves the agency's program including the frequency and detail of the data collection: See L565  o Failure to develop a policy that outlines and tracks adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice See L569  o Failure to ensure that a performance improvement program is in place that can measure success after implementing actions to improve performance and ensure improvements are sustained L570  o Failure to ensure that the hospice developed performance improvement projects based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations See L571, L572.  The cumulative effect of these systemic problems resulted in the hospice's failure to ensure the provision of quality health care and the ability to self identify area in need of improvement. Additionally, this failure to self identify areas in need of improvement has resulted in negative out	L 559	select appropriate performance improvement projects based on the size and complexity of the hospice program.  2. The QAPI Committee will ensure that HPCT's QAPI program is data-driven. This will be evidenced by: <ul style="list-style-type: none"> <li>The identification of quality indicators that assess hospice services, operations and processes of care; 11/30/09</li> <li>Approval of the scope and frequency of data collection by the hospice's governing body; 11/30/09</li> <li>Collection of data related to the selected quality indicators; and Implementation: 12/1/09</li> <li>Analysis of the data to monitor the hospice's quality of services and operations and to select appropriate performance improvement projects based on the size and complexity of the hospice program. Completion 12/18/09 and Ongoing</li> </ul> 3. The hospice's governing body will receive an in-service related to its responsibilities regarding the hospice's QAPI program. Completion 11/18/09 <ul style="list-style-type: none"> <li>The Interim Administrator and leadership team will meet with the governing body to present the revised and updated QAPI program.</li> <li>The governing body will approve the scope and frequency of data collection. Completion 11/30/09</li> </ul>				

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Event ID: NYKK11

Facil

addendum  
The Executive QAPI/Professional Advisor  
Committee is meeting weekly. The POC  
development and action steps are being  
reviewed and QAPI copy 67  
education is reviewed ongoing.

This committee consists of employees,  
Board members and community  
members.

✓ acceptable 11/30/09  
Paula Wilson RN

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD

4277 MIDDLE SETTLEMENT ROAD

NEW HARTFORD, NY 13413

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L 559	Continued From page 67 comes for four patients: #1, 7, 8, 13 and potential negative outcomes for the agency's entire patient population.	L 559	<ul style="list-style-type: none"> <li>These actions will be documented in the governing body minutes.</li> </ul>	11/24/09
L 560	<p>418.58 QUALITY ASSESSMENT &amp; PERFORMANCE IMPROVEMENT</p> <p>The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program.</p> <p>The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.</p> <p>This STANDARD is not met as evidenced by: Based on a review of governing body meeting minutes, continuous quality improvement meeting minutes, policy and procedures and interviews with the Director of Nursing (DON) and the Executive Director, there is no evidence that the hospice has developed an agency wide data driven quality assessment and performance improvement program.</p> <p>Specifically, the surveyor interviewed the DON on 09/11/09 and asked her to identify the quality assessment and performance improvement (QAPI) coordinator. The DON, stated that the QAPI coordinator resigned in August 2009 at</p>	L 560	<p>4. The QAPI Committee will define adverse events in the hospice's policies and procedures and monitor and train staff with regard to reporting adverse events. Reportable incidents include but are not limited to:</p> <ul style="list-style-type: none"> <li>Adverse outcomes, including medical errors</li> <li>Damage to patient, family or hospice property</li> <li>Employee, volunteer, patient or family injury or endangerment including falls;</li> <li>Equipment malfunction or failure;</li> <li>Suicide attempts or ideation</li> <li>Automobile accidents</li> <li>Problems related to the safe use and handling of narcotics; and</li> <li>Violations of privacy and/or security policies and procedures</li> </ul> <p>5. When an adverse event is identified, the following process is implemented by the interim <u>Executive Administrator: Director</u></p>	11/17/09

11/30/09  
accept table  
Paula Williams

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  331510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/29/2009
NAME OF PROVIDER OR SUPPLIER  HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413		
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L 559	Continued From page 67 comes for four patients: #1, 7, 8, 13 and potential negative outcomes for the agency's entire patient population.	L 559	a. An incident report is completed by the staff member who first becomes aware of the incident or adverse event.		
L 560	418:58 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT  The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.  This STANDARD is not met as evidenced by: Based on a review of governing body meeting minutes, continuous quality improvement meeting minutes, policy and procedures and interviews with the Director of Nursing (DON) and the Executive Director, there is no evidence that the hospice has developed an agency wide data driven quality assessment and performance improvement program.  Specifically, the surveyor interviewed the DON on 09/11/09 and asked her to identify the quality assessment and performance improvement (QAPI) coordinator. The DON, stated that the QAPI coordinator resigned in August 2009 at	L 560	b. The adverse event is discussed during the daily "stand-up" and/or the weekly IDT meetings. c. Incident-related investigation and appropriate follow up are documented to ensure that any ongoing or future risks are identified and, if possible, minimized. d. The QAPI Committee will conduct monthly audits of all adverse event reports received the prior month to identify and address possible trends. e. A report of the monthly audit findings, as well as any incident- related trends, will be presented to the QAPI committee on a monthly basis. ONGOING 6. HPCI will identify appropriate performance improvement projects based on data included in the Statement of Deficiencies dated October 29, 2009. Given that the deficiencies contained therein evidence past performance in need of improvement, performance improvement projects identified throughout this plan of correction will assist in correcting deficiencies and improving the quality of care provided to the hospice's patient's and families. a. HPCI will ensure that the performance improvement projects selected based on the Statement of Deficiencies dated		

11/20/09 acceptable Paulagumaan  
68A  
RW

11 Continuation sheet Page 58 of 8

acceptance  
P. Williams  
11/30/05

NAME OF PROVIDER OR SUPPLIER HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413	
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L 560	Continued From page 68 which time she assumed the additional responsibilities as the QAPI coordinator.  The surveyor asked the DON to give an overview of the QAPI program. The DON stated that the agency has a committee that meets monthly called the Continuous Quality Improvement (CQI) committee. The purpose of this committee is to implement the "2009 Monitoring Plan". The surveyor requested a copy of the policy for QAPI. The DON stated that they do not have such a policy.  The hospice does not have a policy describing their quality assessment and performance improvement program and the 2009 Monitoring plan does not include the following components:  - indicators related to palliative outcomes and hospice services  - quality indicator data, including patient care, and other relevant data, in the design of its program to monitor the effectiveness and safety of services and quality of care; and identify opportunities and priorities for improvement.  - a plan to measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.  - there is no plan to ensure that the performance improvement activities affect palliative outcomes, patient safety, and quality of care  The 2009 Monitoring Plan does state that the agency will conduct comprehensive record	L 560	9. The QAPI Committee will ensure that education regarding the hospice's QAPI program is provided to staff and volunteers utilizing resources from the Hospice Education Network.  10. 1 RN staff member and the Governing Board of Directors President to attend NY State DOH funded QAPI Training.  11. Education will be provided to the hospice governing body regarding its executive responsibilities with regard to the hospice's QAPI program. <b>COMPLETION DATE: INITIAL EDUCATION: 10/28/09 UPDATED EDUCATION: 11/18/09</b>

11/30/09

12/1/09

Initial  
education  
10/28/09  
Updated:  
11/18/09

✓  
accept  
11/30/09  
Paula Williams MD

331510		B. WING		10/29/2009	
NAME OF PROVIDER OR SUPPLIER HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413		
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L 560	Continued From page 69 reviews and focused record reviews for nursing. The monthly CQI meeting minutes were reviewed from 01/27/09 to 07/14/09. The meeting minutes lacked evidence of comprehensive record reviews and or focused record reviews for nursing.  This was discussed with the Executive Director on 08/24/09, and stated that the agency had not performed record reviews since December 2008. The Executive Director stated that they just did not have the enough personnel to perform record reviews.  On 09/11/09, the surveyor reviewed the above information with the DON and Executive Director. No further information was provided.  Failure of the hospice to ensure that a quality assessment and performance program is developed has the potential for unmet patient needs and the inability of the hospice to assess quality.	L 560	§ 418.58(a)(1) PROGRAM SCOPE Please refer to L559 # 1 HPCI's QAPI program is being revised. Policies and procedures describe the scope of the program and the QAPI plan details the scope and frequency of data to be collected.	12/07/09 and Ongoing	
L 561	418.58(a)(1) PROGRAM SCOPE  (1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.  This STANDARD is not met as evidenced by: Based on a review of the agency's quality assessment and improvement program, policies and procedures and interviews with the Director of Nursing (DON) and Executive Director there was no evidence that the agency program is capable of measuring improvement related to palliative outcomes. The agency program does not include data driven quality indicators. The	L561	1. The Interim Administrator and the hospice's QAPI Committee will ensure that the hospice's QAPI program provides for measurable improvement in indicators related to palliative outcomes and hospice services. This will be evidenced by: a. The identification of quality indicators that assess hospice services, operations and processes of care; b. Collection of data related to the selected quality indicators; and c. Analysis of the data to select appropriate performance improvement projects based on the size and complexity of the hospice program.	12/04/09	

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d. refer back to  
L560 regarding frequency  
of data collection.

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NAME OF PROVIDER OR SUPPLIER

HOSPICE AND PALLIATIVE CARE, INC NEW HARTFORD

STREET ADDRESS, CITY, STATE, ZIP CODE

4277 MIDDLE SETTLEMENT ROAD

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DEFICIENCY)(X5)  
COMPLETION  
DATE

L 561

Continued From page 70  
agency uses only the information from  
satisfaction surveys to assess agency quality  
status.

On 09/11/09 an interview was conducted by the  
surveyor with the DON regarding the agency's  
quality assessment program. The DON stated  
that the agency does not have an established  
program that can measure improvement in  
palliative outcomes. Additionally, the agency  
does not have a policy in place that outlines the  
program.

L 562

418.58(a)(2) PROGRAM SCOPE

(2) The hospice must measure, analyze, and  
track quality indicators, including adverse patient  
events, and other aspects of performance that  
enable the hospice to assess processes of care,  
hospice services, and operations.

This STANDARD is not met as evidenced by:  
Based on a review of the policies and procedures,  
quality assessment and improvement meeting  
minutes, governing body minutes and interviews  
with the Director of Nursing and the Executive  
Director, there is no evidence that the agency has  
developed quality indicators that will assess  
hospice care, services, operations and adverse  
patient events.

On 09/11/09 and again on 10/03/09, the surveyor  
asked the DON for a policy that defines the  
agency program for quality assessment and  
improvement. The DON stated that the agency  
does not have a policy for their quality  
assessment and performance improvement  
program.

Failure to develop a policy that defines the

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD

4277 MIDDLE SETTLEMENT ROAD  
NEW HARTFORD, NY 13413(X4) ID  
PREFIX  
TAGSUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)ID  
PREFIX  
TAGPROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
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DEFICIENCY)(X5)  
COMPLETION  
DATE

L 562

Continued From page 71

agency quality assessment and improvement program has left the agency without an mechanism for self assessment and ability to determine quality of care assessment.

L 564

418.58(b)(2) PROGRAM DATA

(2) The hospice must use the data collected to do the following:

- (i) Monitor the effectiveness and safety of services and quality of care.
- (ii) Identify opportunities and priorities for improvement.

This STANDARD is not met as evidenced by: See L562

L 565

418.58(b)(3) PROGRAM DATA

(3) The frequency and detail of the data collection must be approved by the hospice's governing body.

This STANDARD is not met as evidenced by: Although the governing body received a copy of the 2009 Monitoring Plan during the February 2009 governing body meeting, there is a lack of evidence that the plan contained the frequency and detail of the data collection process. The fact that the agency has not developed a policy for their quality assessment and performance improvement plan, confirms that the governing body has not reviewed and approved any component.

Failure of the governing body to approve a complete plan for quality monitoring has resulted in the hospice's inability to determine quality of care issues as outlined in this report.

L564

418.58(b)(2) PROGRAM DATA

The Interim Administrator will oversee review of existing data process

- QAPI committee to identify and document:
  - o All performance improvement projects being conducted
  - o The reasons for conducting these projects
  - o Measurable progress achieved during performance improvement projects; and
  - o Evidence that demonstrates the operation of the hospice's QAPI program
- Through the comprehensive assessments and use of family satisfaction surveys, data is collected regarding patient and family outcomes related to the following measures:
  - o Assessment within 72 hours of patient response to question: Was your pain brought to a comfortable level within 48 hrs (2 days) after admission.
  - o Assessment of Skin Integrity, with the identification of Pruritis, Wounds, and Pressure ulcers and compliance with Wound Procedure
  - o Fall Risk Assessment and Fall rates

Implement  
ed 12/1/09  
Ongoing

Executive Director

11/30/09  
acceptable Ruby Williams CW HNS

725 A

331510		B. WING		G 10/29/2009	
NAME OF PROVIDER OR SUPPLIER  HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 562	Continued From page 71 agency quality assessment and improvement program has left the agency without an mechanism for self assessment and ability to determine quality of care assessment				
L 564	418.58(b)(2) PROGRAM DATA  (2) The hospice must use the data collected to do the following: (i) Monitor the effectiveness and safety of services and quality of care. (ii) Identify opportunities and priorities for improvement.  This STANDARD is not met as evidenced by: See L562		<ul style="list-style-type: none"> <li>QAPI committee is responsible for reviewing and analyzing routine data that is collected by the hospice program to include: <ul style="list-style-type: none"> <li>Average and median lengths of stay</li> <li>Utilization of levels of care</li> <li>Referral patterns and delays in admission and or provision of services</li> <li>Complaint and incident report logs</li> <li>Infection surveillance data</li> <li>Staff and volunteer surveys</li> <li>Patient/family satisfaction surveys; and</li> <li>Clinical record review and monitoring</li> </ul> </li> </ul>		
L 565	418.58(b)(3) PROGRAM DATA  (3) The frequency and detail of the data collection must be approved by the hospice's governing body.  This STANDARD is not met as evidenced by: Although the governing body received a copy of the 2009 Monitoring Plan during the February 2009 governing body meeting, there is a lack of evidence that the plan contained the frequency and detail of the data collection process. The fact that the agency has not developed a policy for their quality assessment and performance improvement plan, confirms that the governing body has not reviewed and approved any component.  Failure of the governing body to approve a complete plan for quality monitoring has resulted in the hospice's inability to determine quality of care issues as outlined in this report.		<ul style="list-style-type: none"> <li>The Interim Administrator is responsible for reviewing reports from the QAPI Committee and analyzing data collated related to the financial performance of the hospice including <ul style="list-style-type: none"> <li>Staff productivity and services provided</li> <li>Patient costs per day</li> <li>Additional cost report related data</li> <li>Accounts receivable and payable</li> <li>Status of the annual operating budget</li> </ul> </li> </ul>	Executive Director	

L565

**418.58(b)(3) PROGRAM DATA**  
Communication of all QAPI activities and projects are documented in QAPI Committee meeting minutes and communicated throughout the hospice and to the organization's governing body.

Ongoing

11/30/09  
acceptable  
P JW

pg. 72B

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L 565	Continued From page 72 The results of the governing body meeting minutes review were discussed with the Executive Director on 09/10/09, no further information was provided.			
L 569	418.58(c)(2) PROGRAM ACTIVITIES  (2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.	L570	<p>§ 418.58(c)(3) PROGRAM ACTIVITIES 12/7/09</p> <p>Please refer to L559 # 1 and 8 and L569.</p> <ul style="list-style-type: none"> <li>• Performance improvement activities and projects are selected that: <ul style="list-style-type: none"> <li>○ Focus on high risk; high volume and problem prone areas</li> <li>○ Consider incidence, prevalence and severity of problems in high risk; high volume and problem prone areas</li> <li>○ Affect palliative outcomes, patient safety and quality of care</li> </ul> </li> <li>• QAPI committee to determine 2010 plan and present to governing body</li> </ul>	
L 570	This STANDARD is not met as evidenced by: See L561 418.58(c)(3) PROGRAM ACTIVITIES  (3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.			
L 571	This STANDARD is not met as evidenced by: See L561 418.58(d) PERFORMANCE IMPROVEMENT PROJECTS  Beginning February 2, 2009, hospices must develop, implement and evaluate performance improvement projects.	L571	<p>§ 418.58(d) Performance Improvement Projects</p> <p>Please refer to L559 # 2</p> <ul style="list-style-type: none"> <li>• Initial PIP id. focused on pain, skin integrity and falls as related to safe and comfortable dying.</li> </ul>	
	This STANDARD is not met as evidenced by: Based on a review of the hospice's policies and procedures and interviews with the Director of Nursing and Executive Director, there is a lack of evidence that the hospice has developed performance improvement projects.  Specifically, on 09/11/09, the surveyor			

✓  
acceptable

11/30/09

Powerlasker

73

NAME OF PROVIDER OR SUPPLIER

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L 572

418.58(d)(1) PERFORMANCE IMPROVEMENT  
PROJECTS

(1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations.

This STANDARD is not met as evidenced by: Based on an interview with the Director of Nursing and Executive Director and review of the agency's policies and procedures, there is no evidence that the hospice has identified areas in need of performance improvement and developed projects to assess performance. An interview with the Executive Director and Director of Nursing completed on 09/11/09 confirmed that the hospice has not develop performance improvement projects.

See L571.

L 591

418.64(b)(1) NURSING SERVICES

(1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.

This STANDARD is not met as evidenced by: Based on a review of 14 clinical records, policies and procedures and interviews with the Director of Nursing, Executive Director and agency staff,

L572

§ 418.58(d)(1) Performance Improvement Projects 12/7/09

Please refer to L559 # 2

- Initial PIP to focus as stated above
- QAPI committee to identify 2010 plan

✓  
acceptable  
PW

pg 74

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L 591	Continued From page 75 there is no evidence in 14 records that there was consistent nursing supervision of the patient care and that the patient's nursing needs are being met.  Failure to ensure that the nursing needs of patient and family are met has led to a lack of symptom management and negative outcomes for 4 patients # 1, 7, 8, 13 and the potential for negative outcomes for the agency's patient population.  Although the hospice has structured its program to include patient care managers to provide supervision, the agency has failed to ensure that patient care managers, primary nurses, and on-call nurses have a clear understanding of their role in the provision of nursing services.  See L524, L533, L538, L539, L540	L 591	<p><b>§ 418.64(b)(1) NURSING SERVICES</b> 11/16/09</p> <p>In addition to the corrective actions detailed at L524, L533, L538, L539 and L540, the following corrective actions address the deficiencies cited at L591: <i>Executive Director</i></p> <ol style="list-style-type: none"> <li>The Interim <i>Administrator</i> will ensure that the nursing team members attend an in-service on the RNs responsibility in patient care supervision and coordination of care that includes: <ol style="list-style-type: none"> <li>The role of the <i>Director</i> of Clinical Services/Clinical Supervisor(s), primary nurse(s) registered nurses(s), and on-call nurse(s) in coordination of care and supervision of nursing services.</li> <li>Components of RN supervision: clinical record review, verbal or written instruction, plan of care review, and observation in the clinical area.</li> <li>Documentation of the in-service content and attendance will be maintained.</li> </ol> </li> <li>Policy on Nursing Services approved by Governing Body</li> </ol>
L 648	418.100 ORGANIZATIONAL ENVIRONMENT  This CONDITION is not met as evidenced by: o. Failure to ensure that initial and comprehensive assessments are of sufficient scope to identify the total needs of the patient and family See L524  o Failure to ensure that comprehensive assessments are updated and include information regarding the patient's progress towards desired outcomes and response to care provided. See L533  o Failure to ensure that the comprehensive assessments contain data elements that allow for measuring patient outcomes and are used in individual patient care planning and in coordination of services. See L535.	3.	<p>RN supervision: Each RN will be observed during a patient visit by either the Director of Clinical Services, Clinical Supervisor, Interim Executive Director or other qualified RN. Any issues with patient care that need to be addressed will be done at the visit. Further coaching will occur if needed after the visit by doing an overview with the RN. A form will be developed to document the visit outcome. 12/1/09 completion</p> <p>The clinical documentation each RN completes will be included in the 100% initial and comprehensive assessment audit that will be performed as previously stated. Coaching will occur for issues or needs that are found with each RN immediately and will be documented by the Clinical Supervisor.</p> <p>Annually a supervised patient visit will occur for each RN as part of their annual performance evaluation. Any identified education need or care issue could result in a supervised visit at any time.</p>

✓  
acceptable  
Pw...  
pg 75

331510		B. WING	C 10/29/2009
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L 591	Continued From page 75 there is no evidence in 14 records that there was consistent nursing supervision of the patient care and that the patient's nursing needs are being met.  Failure to ensure that the nursing needs of patient and family are met has led to a lack of symptom management and negative outcomes for 4 patients # 1, 7, 8, 13 and the potential for negative outcomes for the agency's patient population.  Although the hospice has structured its program to include patient care managers to provide supervision, the agency has failed to ensure that patient care managers, primary nurses, and on-call nurses have a clear understanding of their role in the provision of nursing services.	L 591	
L 648	See L524, L533, L538, L539, L540 418.100 ORGANIZATIONAL ENVIRONMENT  This CONDITION is not met as evidenced by: o Failure to ensure that initial and comprehensive assessments are of sufficient scope to identify the total needs of the patient and family See L524  o Failure to ensure that comprehensive assessments are updated and include information regarding the patient's progress towards desired outcomes and response to care provided. See L533  o Failure to ensure that the comprehensive assessments contain data elements that allow for measuring patient outcomes and are used in individual patient care planning and in coordination of services. See L535.	L648	<p>§ 418.100 ORGANIZATIONAL ENVIRONMENT</p> <p>Please refer to the corrective actions, persons responsible and completion dates detailed at L524, L533, L535, L538, L539, L540, L543, L548, L553, L560, L655, and L763.</p> <ul style="list-style-type: none"> <li>Revised initial and comprehensive assessments and provided education to staff on use of tools</li> <li>Ensured new assessment tools contain data elements to measure outcomes and can be effectively used in care planning</li> <li>Revised care planning process</li> <li>Revised and implemented QAPI program</li> </ul> <p>11/30/09 accept A</p>

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L 648	<p>Continued From page 76</p> <ul style="list-style-type: none"> <li>o Failure to ensure that a system is in place to ensure that the registered nurses fulfilling the roles and responsibilities of patient care, supervision, and coordination of care. See L524, L533, L539, L540</li> <li>o Failure to ensure that written plans of care are individualized; specify care and services to meet the needs identified in the comprehensive assessment; reflects patient and family goals; includes a detailed scope and frequency of services including measurable outcomes. See L538, L 540, L543, L545, L548.</li> <li>o Failure to ensure that the interdisciplinary group reviews and revises the plan of care; that the revised plan of care includes information from the patient's updated comprehensive assessment and includes the patient's progress towards outcomes and goals; that there is a system in place to ensure coordination and supervision of the care and services provided. See L539, L553</li> <li>o Failure to ensure that the hospice develops and implements a program for continuous quality assessment and performance improvement. See L560</li> <li>o Failure to ensure that the hospice provides professional management of care provided to patient's residing in the skilled nursing facility. See L655</li> <li>o Failure to ensure that the hospice enters into a written agreement that specifies the provision of hospice services in the facility. See L763</li> </ul> <p>The cumulative effect of these systemic problems</p>	L 648		



## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

331510

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

C

10/29/2009

NAME OF PROVIDER OR SUPPLIER

HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD

STREET ADDRESS, CITY, STATE, ZIP CODE

4277 MIDDLE SETTLEMENT ROAD

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COMPLETION  
DATE

L 648

Continued From page 77

resulted in the hospice's failure to ensure the provision of quality health care. Additionally, this failure to provide oversight resulted in negative outcomes for four patients: #1, 7, 8, 13 and potential negative outcomes for the agency's entire patient population.

L 650

418.100(a) SERVING THE HOSPICE PATIENT AND FAMILY

The hospice must provide hospice care that:  
(1) Optimizes comfort and dignity; and  
(2) Is consistent with patient and family needs and goals, with patient needs and goals as priority.

This STANDARD is not met as evidenced by:  
Based on a review of 14 clinical records and review of the hospices total program, there is a lack of evidence that the hospice provides care that is consistent with patient and family needs and goals. There is a lack of evidence that the hospice program has the skill and expertise to ensure that the needs of all of it's patients and families. The scope of this report identifies the agency's failure to ensure that care provided by the hospice optimizes comfort and dignity.

Failure to ensure quality care has resulted in the unmet patient needs.

See L538, L539

L 651

418.100(b) GOVERNING BODY AND ADMINISTRATOR

A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment

L 648

L 650

**§ 418.100(a) SERVING THE HOSPICE PATIENT AND FAMILY**

To ensure the hospice provides hospice care that optimizes comfort and dignity and is consistent with the patient and family needs and goals, the following corrective measures will be completed by the specified date:

1. In response to the Statement of Deficiencies dated 10/29/09, the hospice's governing body and Interim Administrator are implementing all corrective actions identified in this Plan of Correction with the goal of ensuring compliance with regulations and the provision of high quality care and services.
2. The governing body of HPCI is demonstrating its commitment to improving the quality of care provided by the hospice by the appointment of an Interim Administrator and allocating resources for retaining additional outside expertise to assist in the complete and thorough implementation of this Plan of Correction.

L 651

**§ 418.100(b) GOVERNING BODY AND ADMINISTRATOR**

In addition to the corrective actions detailed at L524, L533, L535, L539B, L539, L540, and L560 the following corrective actions have also been implemented to address the deficiencies cited at L651.

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NEW HARTFORD, NY 13413

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L 651	<p>Continued From page 78</p> <p>and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 14 clinical records, Governing Body Meeting Minutes, Continuous Quality Improvement meeting minutes from August 26, 2008 to August 26, 2009, interviews with the Executive Director, Director of Nursing and Patient Care Manager, there is a lack of evidence that the Administrator appointed by the governing body is fulfilling the responsibilities responsible for the day to day operation of the hospice:</p> <p>o Ensuring the implementation of plan of corrective action pursuant to the December 1, 2008 recertification survey. A post-certification survey was initiated on August 21, 2009, during the survey, the surveyor interviewed the Director of Nursing and Executive Director. Both stated that there have been many staffing issues which prevented them from implementing the plan of correction. Failure to implement the plan of correction has resulted in repeat deficient practices that include: incomplete assessments and plans of care; an inadequate quality assurance and performance improvement program that self identifies areas in need of improvement; an interdisciplinary group that failed to provide supervision of hospice care and services; and the inability to provide adequate skilled nursing services.</p>	L651	<p><b>§ 418.100(b) GOVERNING BODY AND ADMINISTRATOR</b></p> <p>In addition to the corrective actions detailed at L524, L533, L535, L5398, L539, L540, and L560 the following corrective actions have also been implemented to address the deficiencies cited at L651.</p> <ol style="list-style-type: none"> <li>1. The governing body of HPCI has retained outside consultation from Weatherbee Resources, Inc, a nationally known and highly regarded hospice consulting firm. This consultation assisted with a baseline compliance audit and provides assistance to the Interim Administrator to ensure that all components of this plan of correction are implemented by the specified dates. <i>Executive Director</i></li> <li>2. The Administrator contracted with Ann Tonzi for clinical leadership and compliance support. <i>09/18/09</i></li> <li>3. The governing body appointed Ann Tonzi as Interim Administrator to strengthen the hospice's leadership and assist the hospice in the implementation of this Plan of Correction and assume responsibility for HPCI's compliance with regulations and provision of quality care. <i>11/11/09 and Ongoing</i></li> <li>4. The I. Executive Director or designee meets with the leadership team daily and more often as needed to review</li> </ol>	<p>09/30/09 and Ongoing</p>

for progress, compliance, concerns, issues and needs. Smaller groups on on one sessions with clinical leadership occurs daily. Documented on a sign in sheet.

11/30/09  
Acceptable  
P. W. Hansen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  331510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/29/2009
NAME OF PROVIDER OR SUPPLIER  HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
L 651	<p>Continued From page 79</p> <ul style="list-style-type: none"> <li>o Ensuring that comprehensive assessments are of sufficient scope to identify the total needs of the patient and family See L524</li> <li>o Ensuring that the registered nurses are fulfilling the roles of patient care, supervision, and coordination of care. See L524, L533, L535</li> <li>o Ensuring that comprehensive assessments are updated and include information regarding the patient's progress towards desired outcomes and response to care provided. See L533</li> <li>o Ensuring that the comprehensive assessments contain data elements that allow for measuring patient outcomes and are used in individual patient care planning and in coordination of services. See L535.</li> <li>o Ensuring that plans of care are individualized; specify the hospice care and services necessary to meet the patient and family-specific needs. See 538</li> <li>o Ensuring that the coordination of care and continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care is facilitated by a registered nurse. See L539, L540</li> <li>o Ensuring that the hospice implements a program for continuous quality assessment and performance improvement. See L560</li> </ul> <p>Failure of the administrator to provide management of the day to day operations of the hospice has resulted in negative outcomes for 4 patients # 1, 7, 8, 13 and the potential for negative outcomes for the entire patient</p>	L 651			

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L 651

Continued From page 80

L655

L 655

418.100(e) PROFESSIONAL MANAGEMENT  
RESPONSIBILITY

A hospice that has a written agreement with another agency, individual, or organization to furnish any services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of quality care. Arranged services must be supported by written agreements that require that all services be--

- (1) Authorized by the hospice;
- (2) Furnished in a safe and effective manner by qualified personnel; and
- (3) Delivered in accordance with the patient's plan of care.

This STANDARD is not met as evidenced by: Based on a review of 2 clinical records for patients who reside in a skilled nursing facility (#5 and #14) and interviews with the hospice Medical Director, Executive Director and the Director of Nursing (DON), there is a lack of evidence that the hospice provided oversight of staff and services provided to 2 (100%) patients residing in the skilled nursing facility (SNF).

Failure to provide professional management of care and services provided to patient's residing in the skilled nursing services has the potential for unmet symptom management.

1. Patient #5 was admitted to the hospice on 06/08/09 with a diagnosis of Thymus cancer. The patient was admitted to the skilled nursing facility (SNF) on 04/30/09. The hospice nurse failed to adequately assess and monitor the patient's pain

**§ 418.100(e) PROFESSIONAL  
MANAGEMENT RESPONSIBILITY**

To ensure that the hospice provides professional management of care and services provided to patients residing in a SNF/NF or ICF/MR, the following corrective measures will be completed by the date specified:

1. The Interim Administrator will ensure that the IDG team members attend an in-service on providing hospice care to residents of a SNF/NF or ICF/MR that includes the following:
  - a. The organization's policy on caring for hospice patients in a SNF/NF or ICF/MR
  - b. Resident Eligibility for hospice care
  - c. Professional Management
  - d. Contract Provisions
  - e. Hospice POC
  - f. Coordination of Services
  - g. Orientation and training of SNF/NF or ICF/MR staff
2. The hospice has subscribed to the Hospice Education Network's program entitled *Providing Hospice to Residents of a SNF/NF or ICF/MR* that details professional management responsibilities when providing care to residents of a SNF/NF or ICF/MR. All members of the IDG will be required to receive a passing score on the post test for this in-service.

3. The hospice will monitor 20% of SNF patient records per month to assess compliance with our policies and to ensure we are meeting of professional management responsibilities.

✓  
11/30/09 acceptable  
Paula Williams

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD

4277 MIDDLE SETTLEMENT ROAD  
NEW HARTFORD, NY 13413

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 655	<p>Continued From page 81 and cardiac status.</p> <p>Specifically, the hospice nurse visited the patient on 06/22/09 and identified that the patient had a new onset of lower extremity edema. The IDG met on 06/25/09 and incorrectly documented that the patient had edema that was not new and that there were no new interventions. The the hospice nurse failed to update the integrated plan of care following the IDG meeting on 06/25/09 to reflect the new symptom of edema.</p> <p>Additionally, on 09/01/09, at 9:35 am, the surveyor conducted an observational visit with the hospice primary nurse at the skilled nursing facility. During the visit the surveyor asked the hospice nurse to explain her process for ensuring continuity of care and care oversight. The hospice nurse stated that she comes in to see the patient and reviews the SNF record to see if any changes had occurred since her last visit. The hospice nurse also states that she interviews the charge nurse to determine pain control and medication use.</p> <p>The surveyor reviewed the SNF record including the progress notes and medication administration record from 07/10/09 to 08/26/09. The progress notes included a note dated 08/12/09 that the patient had pain in the left shoulder and requested a cortisone shot. The note was written by the nurse practitioner at the SNF. On 09/03/09, the surveyor observed the interdisciplinary group (IDG) meeting, during the meeting this patient was reviewed by the hospice nurse with the team.</p> <p>There was no discussion of the patient's need for a cortisone shot or that she was even having shoulder pain. At the conclusion of the IDG</p>	L 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  331510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/29/2009
NAME OF PROVIDER OR SUPPLIER  HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
L 655	<p>Continued From page 82</p> <p>meeting, the surveyor interviewed the Medical Director. The surveyor asked the Medical Director if the patient receiving a cortisone shot for pain was something that should have been discussed during the IDG and if the hospice would have input prior to administration? The Medical Director stated that yes it should have been discussed prior to administration however, he was unaware that the patient needed the injection.</p> <p>There is no evidence that the patient's symptoms are being reported to, authorized and managed by the hospice. There is no evidence that the cortisone injection was administered in accordance with the hospice plan of care.</p> <p>The DON and Executive Director were both at the IDG meeting when this record was reviewed with the Medical Director on 09/03/09. No further information was provided.</p> <p>2. Patient # 14 was admitted to the hospice on 07/21/09 with a diagnosis of dementia and to the skilled nursing facility in 2007. The hospice failed to provide adequate assessment and oversight of the patient and family care and services. The comprehensive nursing assessment was completed on 07/21/09 and the social work assessment was completed on 07/31/09.</p> <p>During the nursing assessment visit completed on 07/21/09, the primary nurse identified that the patient had two buttocks wounds measuring # 1 - 1.2 cm x 0.6 cm x 0.15 cm, # 2 - 0.8 cm x 0.8 cm x 0.15 cm. The primary nurse then documented "measured 07/20/09 by skin nurse". There is no evidence that the hospice nurse observed or assessed the actual condition of the wound. The</p>	L 655			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  331510		A. BUILDING _____ B. WING _____		C 10/29/2009	
NAME OF PROVIDER OR SUPPLIER  HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD				STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413			
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L 655	<p>Continued From page 83</p> <p>hospice nurse visited the patient weekly, however, there is no evidence that she ever observed the SNF nurse perform wound care or that the hospice nurse observed the wounds during any of her visits.</p> <p>The plan of care does not indicate that the primary nurse is going to assign the responsibility for wound measurements and assessments to the SNF staff. Additionally, the surveyor attended an IDG meeting on 09/03/09 during which this patient was discussed, there was no discussion about the patient's wound or pressure relieving measures. The only comment was "stage II healing" this statement was only given after the PCM asked the primary nurse about it.</p> <p>On 07/31/09, the social worker completed a comprehensive assessment of the patient and family's psychosocial needs. The social worker documented "family having difficulty adjusting to SNF". The social worker did not note that the patient was admitted to the SNF in 2007. There was also no plan for the hospice social worker to work with this family to ensure that their needs were met in the SNF.</p> <p>On 09/11/09, the surveyor interviewed the social worker and asked if she knew that the patient had been in the facility for 2 years. The social worker stated that yes she knew that the patient had been in the facility for 2 years, but that the family still never quite adjusted and consistently felt that the facility was not providing enough care for the patient.</p> <p>The surveyor asked the social worker to describe the plan developed to resolve the family's issue and where she documented the plan. The social</p>	L 655					

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L 655	Continued From page 84 worker stated that the interventions were part of the integrated SNF plan. The surveyor pointed out that the only plan in the record related to family issues was dated 07/30/09 and the only discipline responsible for interventions on the plan are SNF staff members. The social worker did not have any further information regarding the plan for managing the caregivers stress.	L763	<p><b>§ 418.112(c) WRITTEN AGREEMENT</b> To ensure the hospice and the SNF/NF or ICF/MR has a written agreement that specifies the provision of hospice services in the facility, the following corrective measures will be completed by the date specified:</p> <p><i>Executive Director</i></p> <ol style="list-style-type: none"> <li>1. The interim <del>Administrator</del> sent an updated contract to SNFs/NFs where current hospice patients reside. 10/28/0</li> <li>2. The hospice Administrator will send an updated contract to facilities where no current hospice patients reside, prior to admitting patients at those facilities. Ongoing</li> <li>3. The Interim Administrator developed an implementation plan for review of the contract and sign-off by each facility. 11/11/0 <i>Executive Director</i></li> <li>4. The Interim Administrator created a tickler system for tracking contract renewal due dates to ensure that no vendor contract expires unless a suitable alternative vendor is identified and a contract is 11/11/1</li> </ol> <p>1a. In addition weekly phone calls, emails and in person visits were made to Administrators at SNF's/NH's who have current patients. A summary of the changes to the COP's that would affect the contract between Hospice and the SNF/NH were outlined and e-mailed or delivered in person. The contact with these facilities is documented in a spreadsheet stating the activity/date and time and by whom.</p>	
L 763	<p><b>418.112(c) WRITTEN AGREEMENT</b></p> <p>The hospice and SNF/NF or ICF/MR must have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by authorized representatives of the hospice and the SNF/NF or ICF/MR before the provision of hospice services.</p> <p>This STANDARD is not met as evidenced by: Based on interview with the Executive Director and review of 1 written agreement between the hospice and the skilled nursing facility, there is a lack of evidence that the hospice developed and implemented written agreement based on the new regulatory requirements.</p> <p>An interview with the Executive Director was conducted on August 26, 2009 at 12:00 pm. The surveyor requested contracts for the skilled nursing facilities where residents are currently receiving care. The Executive Director stated that he has not revised the the contracts to meet the regulatory requirements of the new Conditions of Participation dated December 2, 2008.</p> <p>The skilled nursing facility contracts lack the following:</p> <ul style="list-style-type: none"> <li>- The manner in which the skilled nursing facility and the hospice are to communicate with each</li> </ul>			

11/30/09 acceptable  
Paula Williams RN



NAME OF PROVIDER OR SUPPLIER <b>HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 763	Continued From page 85 other and document such communications to ensure that the patient's needs are addressed and met 24 hours a day.  - The delineation of the responsibilities which include medical direction and management of the patient including nursing.  - The provision stating that the hospice must report all alleged violations involving mistreatment, neglect or verbal, mental, sexual and physical abuse  - A delineation of the responsibilities of the hospice and the skilled nursing facility to provide bereavement services to skilled nursing facility staff.  During the August 26, 2009 interview with the Executive Director, the surveyor asked why the contracts were not revised? The Executive Director did not give an explanation.  Failure to ensure that the Hospice has a written agreement that specifies the provision of hospice services has the potential for unmet patient needs.	L 763	2a. Contracts were sent to Administrators where no hospice patients currently reside. In addition weekly phone calls, emails to these SNF/NH Administrators. A summary of the changes to the COP's that would affect the contract between Hospice and the SNF/NH were outlined and e-mailed, faxed or delivered in person. The contact with these facilities is documented in a spreadsheet stating the activity, date, time and by whom.  3a. A detailed spreadsheet has been developed including the date the contract was sent and when it was returned and any additional commentary.  4a. Each SNF/NH contract is ongoing will be reviewed and revisited each year with the Administrator. If the contract is not renewed a plan will be put in place to use an acceptable contracted vendor.	
L 782	418.112(f) ORIENTATION AND TRAINING OF STAFF  Hospice staff must assure orientation of SNF/NF or ICF/MR staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.	L 782 11/30/09	<b>§ 418.112(f) ORIENTATION AND TRAINING OF STAFF</b> To ensure comprehensive hospice orientation of SNF/NF or ICF/MR staff members furnishing care to hospice patients, education including the hospice philosophy, hospice policies and procedures, methods of comfort, pain control, symptom management, as well as, principles about death and dying, individual response to death, patient rights, and appropriate forms and record keeping requirements, the following corrective measures will be completed by the specified date:	

NAME OF PROVIDER OR SUPPLIER HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 4277 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 782	<p>Continued From page 86</p> <p>This STANDARD is not met as evidenced by: Based on a review of education and training documents and interviews with the Director of Nursing (DON), and an observational home visit in a skilled nursing facility, there is a lack of evidence that the hospice provides orientation and training programs to staff at skilled nursing facilities (SNFs).</p> <p>Specifically, the hospice contracts with 15 skilled nursing facilities. On 09/11/09, the surveyor interviewed the Director of Nursing and asked her who provides education to the skilled nursing facilities? The DON stated that she is performing the educator function because the person responsible for educating the SNFs is on leave and not available. The surveyor asked the DON to explain how staff at the SNFs are oriented to the hospice philosophy and receive ongoing training regarding pain and symptom management, roles and responsibilities for professional management, as well as principles of death and dying. The DON stated that they have provided two inservices with the skilled nursing facilities this year, however, neither of the 2 inservices were for orientation to the hospice.</p> <p>The DON also stated that the hospice provided 2 inservices to the local hospitals. When asked if the inservices included an orientation to the hospice philosophy, roles and responsibilities for professional management, the DON stated no, they were for discharge planning to increase awareness of hospice services.</p> <p>On 09/01/09, the surveyor conducted an observational home visit with the hospice primary nurse at the skilled nursing facility. While at the</p>	L 782	<p><del>Executive Director</del></p> <ol style="list-style-type: none"> <li>1. The Interim Administrator will direct the development of an educational binder to be placed in each contracted SNF/NF or ICF/MR that contains pertinent hospice policies/procedures that provide an orientation to the hospice and care of the dying patient. The binder will be updated as needed, or at minimum quarterly. 11/20/09</li> <li>2. The Interim Administrator will oversee the development of a comprehensive education program for SNF/NF or ICF/MR staff members furnishing care to patients that includes, but is not limited to: <ul style="list-style-type: none"> <li>▪ The hospice philosophy</li> <li>▪ Hospice policies and procedures</li> <li>▪ Methods of comfort</li> <li>▪ Pain control and symptom management</li> <li>▪ Principles of death and dying</li> <li>▪ Individual response to death</li> <li>▪ Patient rights</li> <li>▪ Appropriate forms and record keeping requirements</li> </ul> </li> <li>3. The Interim Administrator or designee will contact each SNF/NF or ICF/MR facility, once an updated written agreement has been established, and schedule a date to present the comprehensive hospice education program to all facility employees in accordance with the written contract. Additional education will be provided to the SNF/NF or ICF/MR as needed. 12/04/09 and Ongoing</li> </ol> <p><i>Executive Director</i></p>	

11/30/09  
acceptable  
P. J. Williams

331510

B. WING

10/29/2009

NAME OF PROVIDER OR SUPPLIER

HOSPICE AND PALLIATIVE CARE INC NEW HARTFORD

STREET ADDRESS, CITY, STATE, ZIP CODE

4277 MIDDLE SETTLEMENT ROAD

NEW HARTFORD, NY 13413

(X4) ID  
PREFIX  
TAGSUMMARY STATEMENT OF DEFICIENCIES  
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TAGPROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
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DEFICIENCY)(X5)  
COMPLETION  
DATE

L 782

Continued From page 87.

SNF, the surveyor interviewed the charge nurse (a licensed practical nurse) for patient #5 regarding charge nurse's orientation to hospice philosophy. The charge nurse stated that she had worked at this SNF for a number of years and that she has never had orientation to hospice.

On 09/11/09, this information was shared with the DON who stated that the primary nurse usually gives orientation to nurses and aides from the skilled nursing facility upon admission to hospice.

L 782

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337255	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/09/2009
NAME OF PROVIDER OR SUPPLIER  GENTIVA HEALTH SERVICES LIVERPOOL			STREET ADDRESS, CITY, STATE, ZIP CODE 200 ELWOOD DAVIS ROAD LIVERPOOL, NY 13068		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 000	INITIAL COMMENTS  This statement of deficiencies is the result of a complaint investigation NY00076102. The survey consisted of clinical record reviews for 3 patients, interviews with the Administrator and agency staff.  The allegation was substantiated.	G 000			
G 159	(*) indicates a repeat deficiency 484.18(a) PLAN OF CARE  The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury. Instructions for timely discharge or referral, and any other appropriate items.  This STANDARD is not met as evidenced by: Based on a review of 3 clinical records and interviews with the Administrator and agency staff, there is a lack of evidence in 1 record that the agency developed a complete plan of care to meet the patient's needs. Patient #1  Failure to develop a complete plan of care has resulted in unmet patient needs.  Patient # 1 was admitted to the agency on 08/20/08, with a diagnosis of cerebral palsy, mental retardation, and placement of a percutaneous endoscopic gastrostomy (PEG) feeding tube in June 2009. The plan of care	G 159	G 159 484.18(a) Plan of care  The lack of a holistic plan of care with patient number one has been addressed as follows:  1.) The MCP/preceptor will make a joint OASIS SOC visit with the clinician and review the documentation with respect to this visit. Based on this visit and review it will be determined if the clinician needs additional mentoring. The QA nurse will focus on her SOC assessments and work with her to improve her documentation. If issues continue with the documentation the clinician will be placed on an action plan and disciplinary action will be implemented by the MCP/designee.  2.) The SOC case conference is completed for all new admissions. During this conference any unmet needs will be discussed and recommendations made by the MCP/designee. Additional interventions and goals will be added as deemed appropriate.		12/15/09  12/15/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

*Virginia Martinez RN ADPS*

11/23/09

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  GENTIVA HEALTH SERVICES LIVERPOOL			STREET ADDRESS, CITY, STATE, ZIP CODE 200 ELWOOD DAVIS ROAD LIVERPOOL, NY 13088		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 159	<p>Continued From page 1</p> <p>dated 08/15/09 failed to include the following:</p> <ul style="list-style-type: none"> <li>- care of the PEG feeding tube: Specifically, the plan of care states "patient/caregiver manages peg-tube care, feedings, flushes with proficiency". The plan of care failed to include specifics related to PEG tube "care" including: cleansing the insertion site and the frequency for care; the amount of Jevity feedings over a 24-hour period and a plan to ensure that the patient tolerates the feedings; the amount and solution that is used for flushing the PEG tube after medication administration.</li> <li>- integumentary interventions: The plan states assess skin every visit, however, there is no plan to assess the insertion site of the PEG tube.</li> <li>- neurological interventions: The plan states assess seizure precautions. There is no plan to assess the patient's seizure activity or neurological status.</li> <li>- a skilled nursing frequency that meets the on-going needs of the patient. The plan of care identified the above interventions however, there is no evidence of how the patient's needs for skilled nursing assessments will be met after the patient's discharge from the agency on 08/21/09.</li> <li>- clarification of the statement: "Discharge Plans: Plan to discharge patient 08/21/09 to longterm care". Specifically, there is no documentation in the clinical record of a referral given and accepted by any long term care program.</li> </ul> <p>This record was reviewed by the surveyor with the Administrator on 09/15/09. The Administrator confirmed that the patient was discharged on</p>	G 159	<p>3.) The 10% chart audit process continues by the MCP/QA/RD staff to identify trend or patterns of documentation needing improvement and is brought to the quarterly PAC meeting where action plans are developed to improve documentation below benchmark.</p> <p>4.) The patient is discharged and no longer receives services from the agency.</p> <p>Responsible parties: The ADPS/AD.</p>		12/15/09

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 11/12/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337255	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/09/2009
NAME OF PROVIDER OR SUPPLIER  GENTIVA HEALTH SERVICES LIVERPOOL			STREET ADDRESS, CITY, STATE, ZIP CODE 200 ELWOOD DAVIS ROAD LIVERPOOL, NY 13088		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 159	Continued From page 2 08/21/09, without regard for the patient assessment findings noted on 08/17/09. The 08/17/09 assessment identified that the patient had new onset abnormal lung sounds and an increase in the amount of tube feeding administered each hour. The patient is to have nothing by mouth.	G 159			
G 339	* Repeat Deficiency noted in the 04/15/09 and 08/20/09 surveys 484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT  The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer, or significant change in condition resulting in a new case mix assessment, or discharge and return to the same HHA during the 60 day episode.  This STANDARD is not met as evidenced by: Based on a review of 3 clinical records and interviews with the agency Administrator, there is a lack of evidence in one record that the skilled nurse completed a comprehensive assessment in the last 5 days of the 60 day certification period. Patient #1  Failure to update the comprehensive assessment in a timely manner has the potential for unmet patient needs.  1. Patient # 1 was admitted to the agency on 08/20/08 with a primary diagnoses of cerebral	G 339	G 339 484.55 (d) (1) UPDATE OF THE COMPREHENSIVE ASSESSMENT This was an exception with the patient number one. It was decided with MD notification that the skilled RN case manager should do the recertification upon her return from vacation as she was familiar with her patient. This did as stated make the recertification 3 days late according to regulations. This is not a trend or pattern within the agency but an isolated incident to ensure the patient still had skilled needs. At the agency's daily meeting it is ensured that all recertification's are scheduled and completed within the 5 day window of the recertification due report. This ensures that recertification's are timely per OASIS regulations.		11/30/09

PRINTED: 11/12/2009  
 FORM APPROVED  
 OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER

GENTIVA HEALTH SERVICES LIVERPOOL

STREET ADDRESS, CITY, STATE, ZIP CODE

200 ELWOOD DAVIS ROAD  
 LIVERPOOL, NY 13088

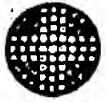
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 339	<p>Continued From page 3</p> <p>palsy, mental retardation, and convulsions. The skilled nurse failed to complete an updated comprehensive assessment within the last 5 days of the 60 day certification period. Specifically, for the certification period 08/15/09 to 08/14/09, the comprehensive assessment was not completed until 08/17/09, three days after the expiration of the certification period.</p> <p>On 09/15/09, an interview with the Administrator was completed by the surveyor. The Surveyor asked the Administrator why the assessment was not done until after the certification period was over? The Administrator stated that she wanted the case manager to do the assessment because she knew the patient and that she was not available until 08/17/09 to perform the comprehensive assessment.</p>	G 339	<p>The MCPs will make sure that at every daily meeting, each of their patients are scheduled for a recertification visit within the required 5 day window. There will not be an exception permitted for an employee's absence and the assessment will be completed timely.</p> <p>A 10 % audit of the the daily meeting log will be utilized to report on the compliance with 100% of patients recertified within the 5 day window. The results will be reported in PIPAC meetings quarterly.</p> <p>Responsible parties: MCP, QA RN, ADPS, Administrator.</p>	

*11-24-09 acceptable*  
*Paula Williams RN*

JAN. 14. 2010 10:10AM

GENTIVA

NO. 9127 P. 2/14



**GENTIVA®**  
home health

great healthcare has come home™

NY00078315

Lynn Shannon  
Home and Community Based Program manager  
217 South Salina St  
Syracuse, NY 13202

accepted  
1/19/10  
H. [Signature]

Re: Complaint Survey NY0078315  
Gentiva Health Services  
Medicare Provider #337224  
Event#QVVF11

Dear Ms. Shannon:

Please accept the enclosed Plan of Correction to the deficiencies statement resultant from the above mentioned survey of December 3rd 2009.

We hope that you find this acceptable. Please do not hesitate to contact me at #607-771-8791x230.

Regards,

Kate Rogers RN CCM  
Branch Administrator



Complaint, 2009

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/15/2009  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/03/2009
NAME OF PROVIDER OR SUPPLIER  GENTIVA HEALTH SERVICES BINGHAMTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1249 FRONT STREET, SUITE 110 BINGHAMTON, NY 13905	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS  This statement of deficiencies is the result of a complaint investigation (#NY00078315) survey. An on-site investigation was initiated on 12/02/09. The survey consisted of a review of 3 clinical records. Interviews were conducted with the agency's Administrator, Acting Director of Patient Services, and one Skilled Nurse.  The complaint was substantiated.  All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.  This STANDARD is not met as evidenced by: Based on a review of 3 clinical records and interviews with the agency's Administrator, Acting Director of Patient Services, and a Skilled Nurse (SN), there is no evidence in 3 records the SNs are consistently functioning in the role of case management/case coordination, or that they have a clear understanding of the role of the home care nurse in providing case management coordination. Patients # 1, 2, 3.  Lack of adequate case management and case coordination has the potential for agency wide unmet patient needs and negative patient outcomes.  Examples are as follows:  1. Patient # 2 was admitted to the agency on 04/29/09. The 04/29/09 initial nursing assessment	G 000	<u>G143-Coordination of Patient Services</u>  The administrator will be responsible for the oversight of the director of clinical practice and the clinical supervisor to ensure that the staff is educated to the role and duties of a case manager. As a case manager the clinician will coordinate, implement and update a POC that meets  G 143 the patients needs and supports the objectives identified in the POC. By 01/15/10, the clinical staff will undergo mandatory attendance "Case Management the definition and application".  To ensure that care is coordinated effectively to support the POC objectives, an ongoing 20% clinical record review of active patients will be done by the supervisory staff effective quarter 1, 2010. An action plan will be developed based on the results of this audit to educate and consult the staff.  The DCM and clinical supervisor will hold mandatory weekly interdisciplinary case conferences with the staff to ensure compliance.  Quarter one 2010 additional supervisory staff will be added in the following manner MCP promoted to DCM, clinical supervisor and clinical team leader will assist the DCM in carrying out the POC. The clinical team leader will also function as a wound care supervisor. These changes have already been implemented.	

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DATE

*Kathleen Rodrix RN ccm Branch Director/Administrator* 01/14/10

Agency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.

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G 143	<p>Continued From page 1</p> <p>documented the patient had a right hip wound. A 04/03/09 physician's progress note documented the wound was a decubitus ulcer which occurred at the surgical site of a previous total hip replacement. The 04/29/09 plan of care included daily dressing changes and wound assessment by the SN.</p> <p>The SN failed to fulfill her role as case manager, and failed to coordinate and implement a plan of care which met the patient's wound care needs. On 06/23/09 the patient was admitted to the hospital with a wound infection. The 06/23/09 hospital physician admitting history and physical documented the patient was admitted with a "large ulcer" of the right hip. The physician documented the patient has had problems with the ulcer now for a fair period of time...the ulcer now has not healed and has foul smelling drainage coming from it. The 07/13/09 hospital physician discharge summary documented the patient died on 07/13/09 with a primary diagnosis of infected right hip. The death certificate documented the immediate cause of death was right hip ulcer and cellulitis. The SN failed to:</p> <ul style="list-style-type: none"> <li>- Coordinate an updated plan of care with the physician. Specifically, on 05/18/09 the SN obtained a wound culture as directed by the physician's office. On 05/18/09, 05/19/09, and 05/20/09 a SN documented on the wound culture report that the SN case manager was "to follow up". The SN case manager, however, failed to follow up with the physician to determine if an updated plan of care was needed based on the wound culture results.</li> </ul> <p>On 05/20/09 the SN visited the patient and documented that the patient had been seen by</p>	G 143	<p>100% record audit of all active wound care patients will be conducted, reviewed and trended. An action plan addressing the outcome of this audit will be presented by January 1<sup>st</sup> 2009. This audit will be conducted by a Gentiva senior staff auditor from outside the branch. The audit will review the coordination of services, the efficiency of the case manager to support the POC objectives, that the objectives relate to/and are pertinent to the diagnoses. An action plan will be developed by the auditor based on the outcome of this audit and be implemented by the newly created position of a supervisory wound care nurse specialist.</p> <p>The DCM and the clinical supervisors will ensure that the case managers will notify the appropriate supervisor when any significant change of condition occurs and will coordinate with the supervisor, via a case conference, to revise the POC, as needed. A mandatory staff in-service will be conducted by 2/15/10 to re-educate the staff using the Gentiva University web conference course "Care Coordination and Documentation."</p> <p><i>Accepted 1/15/10</i></p>	<p>1/10</p> <p>2/15/10</p>

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G 143	<p>Continued From page 2</p> <p>the physician the prior day (05/19/09), and that the physician was waiting for the wound culture results before treating with antibiotics. The SN failed to document who provided her with this information, and there is no evidence the SN contacted the physician.</p> <p>- Coordinate a pressure relief plan for the decubitus ulcer with all caregivers as follows:</p> <p>On 04/23/09 (the day of the patient's admission to the agency), the agency received a fax containing a 04/03/09 physician progress note. The physician documented the patient had a "new right greater trochanteric decubitus ulcer, for which I told her she absolutely needs to stay off that side. She cannot lay on that side. She can try laying on her stomach, which she can tolerate. She does not feel at all comfortable laying on her back or her left side."</p> <p>Although the agency had received the above fax from the physician, and the 04/24/09 plan of care included SN, Physical Therapy (PT), Occupational Therapy (OT), and Home Health Aide services, the SN failed to coordinate a regular repositioning schedule, any pressure relieving devices such as a pressure relieving mattress cover, instructions to the Home Health Aide for repositioning.</p> <p>Additionally, on 06/17/09 the SN documented that the patient could not tolerate the wound vac because she was unable to lay on that side, and removed the wound vac. The SN failed to develop and implement a pressure relief plan including repositioning and pressure relieving devices such as a mattress cover.</p>	G 143	<p>For patients receiving skilled visits to provide wound care, a weekly conference will be held between the SN and the wound care specialist supervisor. As of December 14<sup>th</sup>, 2009, the wound care supervisor will run a report of all wound care patients admitted to service. Documentation of these patients shall be kept in a wound care book. This book contains, but not limited to the following information:</p> <p>weekly progress notes for comparison, treatments, complete wound care orders, weekly case conference notes. This information will also be communicated to the interdisciplinary team via case conference notes on the chart and in weekly conferences. The wound progression will be documented by instituting a new procedure by 2/15/10, in which appropriate wounds will have an initial digital photographic image on file and will be reviewed by the wound care specialist for recommendation. The wound care nurse will then work with the SN and supervisors to develop an ongoing treatment plan, facilitate POC changes and coordinate treatment with the</p> <p>SN via weekly conferences. The SN will report the outcomes to the treating physician, via the wound progress summary/weekly case conferences.</p> <p><i>Accepted 1/19/10</i> <i>H. Demarthe</i></p>	2/15/10	

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G 143	<p>Continued From page 3</p> <p>On 12/03/09 the surveyor interviewed the SN case manager. The SN stated: the patient did not have a pressure ulcer, the wound resulted from a fall on an old surgical site, the patient was not bedbound. On 04/28/09 the OT, however, documented the patient was "very inactive", and on 05/08/09 the PT documented the patient required an electric wheelchair. The SN failed to recognize the patient required a pressure relief plan as identified by the physician.</p> <p>- Coordinate a complete and accurate wound vac plan with the physician. Specifically, on 06/17/09 at 08:10 AM the SN visited the patient and documented she had applied a wound vac. On 06/17/09 at 8:10 PM the SN visited the patient and documented that the patient was uncomfortable with the wound vac, and she had removed the wound vac at the patient's request. The SN, however, failed to document the settings of the wound vac, or the type of foam to be used, and failed to obtain physician orders for either.</p> <p>- Coordinate a complete and accurate plan for dressing changes as directed by the physician. Specifically, on 06/19/09 the SN obtained a verbal order via the physician's nurse to: apply an iodosorb gel dressing to the wound bed every other day until 06/23/09, continue hydrogel dressings on 06/23/09. However, on 06/19/09 and 06/21/09 the SNs, documented performing hydrogel dressings covered with gauze pads. The SNs failed to follow the physician order in effect during that time period for iodosorb gel dressings.</p> <p>Additionally, the prior (05/27/09) physician orders for the hydrogel dressing, which were to be continued/resumed on 06/23/09, specified hydrogel to necrotic tissue in wound, apply</p>	G 143	<p>100% audit of all wound care patients by a senior agency auditor was put into place on 12/14/09. The auditor will prepare a report on these 17 patients to determine the discrepancies in documentation, assessment, orders adherence in following the POC/protocols, patient's progress toward goals and completeness of the clinical notes. The auditor will determine compliance to protocol, identify trends and recommend adjustments by 1/8/10.</p> <p>The responsibility for ongoing 20% random wound care clinical record audits will then be conducted by the wound care specialist and continue throughout 2010 to determine trends and outcomes and develop action plans to address identified problem areas To ensure compliance.</p> <p>These outcomes will be presented and discussed quarterly at the PAC advisory committee meetings, for further follow up, assessment of progress and adjustment.</p> <p>Patient #1-Patient has expired</p> <p>Patient # 2- Patient has expired</p> <p>Patient # 3- SNF placement</p> <p>Accepted 1/19/10 L. DeMonte</p>	1/8/10

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G 143	<p>Continued From page 4</p> <p>xeroform dressing to healthy tissue in and around wound bed, cover with gauze pad. There is no evidence the SNs on 06/19/09 and 06/21/09 applied the xeroform with the hydrogel as previously ordered by the physician. During the interview of the SN case manager by the surveyor, the SN stated that the hydrogel was being used only on a small portion of the wound, and she was not sure of what type of care was provided to the remaining part of the wound from 06/18/09 to the patient's emergency admission to the hospital on 06/23/09.</p> <p>Additionally, the Physical Therapist (PT) failed to coordinate the patient's care with the SN case manager. Specifically, on 06/20/09 the PT documented: the patient was complaining of itching and an odor from the right thigh (wound), had a pain level of 8 out of 10. Although the PT documented communicating to the SN that the patient was being discharged from PT services, the PT failed to assess if the wound did have an odor, communicate his assessment and the patient's observations to the SN and/or physician. As a result, although the SN visited the patient the following day on 06/21/09, the SN failed to assess the wound and assess if the wound had a foul odor.</p> <p>The patient record was reviewed with the agency Administrator and Acting Director of Patient Services on 12/02/09. No additional information was provided.</p> <p>2. Patient # 1 was admitted to the agency on 05/17/09 with a primary diagnosis of left elbow pressure ulcer. The 05/17/09 initial nursing assessment documented the patient was chair fast and was unable to transfer independently.</p>	G 143			

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(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

337224

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

C

12/03/2009

NAME OF PROVIDER OR SUPPLIER

GENTIVA HEALTH SERVICES BINGHAMTON

STREET ADDRESS, CITY, STATE, ZIP CODE

1249 FRONT STREET, SUITE 110

BINGHAMTON, NY 13905

(X4) ID  
PREFIX  
TAG

SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID  
PREFIX  
TAG

PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)

(X5)  
COMPLETION  
DATE

G 143

Continued From page 5

The 05/17/09 plan of care included SN, PT, private aide services, and an Occupational Therapy (OT) evaluation. Although the SN directed the aide to reposition the patient every 2 hours on 05/29/09, the SN failed to coordinate an ongoing pressure relief plan with the patient, PT, OT, the private aide, and the physician, which included scheduled repositioning, and pressure relief devices such as a rojo cushion.

The surveyor interviewed and reviewed the record with the Administrator and the Acting Director of Patient Services on 12/03/09. No further evidence was provided.

3. Patient # 3 was admitted to the agency on 05/07/09. On 05/07/09 the SN documented in the initial nursing assessment the patient had 3 pressure ulcers on her buttocks. The 05/07/09 plan of care included Home Health Aide services. The SN failed to develop and coordinate a pressure relief plan with the patient, Home Health Aide, and physician which included scheduled repositioning, and/or pressure relief devices such as a rojo cushion, or pressure relieving mattress cover, or a PT evaluation.

The surveyor interviewed and reviewed the record with the Administrator and the Acting Director of Patient Services on 12/03/09. No further evidence was provided.

G 159

484.18(a) PLAN OF CARE

The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional

G 143

G 159

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G 159	<p>Continued From page 6</p> <p>limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 3 clinical records and interviews with the agency's Administrator and Acting Director of Patient Services, there is no evidence in 2 records that the plans of care are complete, accurate, and meeting all patient needs. Patients # 1, 3.</p> <p>Lack of adequate plans of care have the potential for unmet patient needs, and possible negative patient outcomes.</p> <p>Examples are as follows:</p> <p>1. Patient # 3 was admitted to the agency on 05/07/09. The 05/07/09 plan of care was incomplete as follows:</p> <ul style="list-style-type: none"> <li>- On the patient's 05/07/09 initial assessment the SN documented a new wound to the patient's right hand, however, the plan failed to include a wound care plan for the hand.</li> <li>- The plan included wound care for buttocks wounds, however, failed to specify the frequency of the dressing changes for these wounds.</li> </ul> <p>The surveyor interviewed and reviewed the record with the Administrator and the Acting Director of Patient Services on 12/03/09. No new evidence was provided.</p>		<p>G-159-Standards of care/ Plan of Care</p> <p>The Administrator will ensure that the DCM or the Clinical Supervisor will have 100% oversight of developing the Individual patient's POC, in conjunction With the clinical staff and based on Diagnosis, clinical documentation, Assessment, case conferencing and review Of all POC changes.</p> <p>The DCM will be responsible for a mandatory in-service to re-educate the staff on the role of the case manager and developing an accurate and complete POC(see above g-143). This will be completed by 02/15/10</p> <p>Ongoing 50% clinical record review Of active patients via wound care audits (see g-143) conducted by the wound care specialist to ensure compliance, assess ongoing training needs and review trends. An action plan for individual clinicians out of compliance will then be addressed by the DCM. If 75% compliance is obtained audit will then be 20% Of active patients.</p> <p>patient #1 see above G-143 patient #2 see above G-143 patient #3 see above G-143</p> <p><i>Accepted 1/15/10</i></p>	2/15/10

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G 159	Continued From page 7  2. Patient # 1 was admitted to the agency on 05/17/09 with a diagnosis of pressure ulcer to the left elbow. The patient's 05/17/09 initial assessment documented 6 wounds to the left elbow. The 05/17/09 plan of care failed to specify wound care for each of the 6 wounds identified by the SN.  The surveyor interviewed and reviewed the record with the Administrator and the Acting Director of Patient Services on 12/03/09. No new evidence was provided.			G 159			
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse regularly re-evaluates the patients nursing needs.  This STANDARD is not met as evidenced by: Based on a review of 3 clinical records and interviews with the agency's Administrator, Acting Director of Patient Services, and Skilled Nurse (SN), there is no evidence in 3 records the SNs are consistently performing complete and accurate nursing assessments. Patients # 1, 2, 3  Failure to perform complete and accurate nursing assessments resulted in a negative outcome for patient #2, and has the potential for agency wide unmet patient needs.  Examples are as follows:  1. Patient # 2 was admitted to the agency on 04/29/09 with a primary diagnosis of pressure ulcer of the right hip. The Skilled Nurse (SN) failed to perform complete and accurate nursing				G-172- Duties of the RN  The Administrator will ensure that The DCM and or the Clinical Supervisor And/ Rehab. Director will conduct A 50% quarterly clinical record review for comprehensiveness of documentation to identify, monitor and correct deficient areas. Individual clinical staff counseling will be based on the findings and carried out by the DCM. If compliance to complete and accurate assessments and follow up is obtained, audits will then be 20% of active census.  The Wound Care Specialist will hold an in-service for all RN staff using Gentiva University modules Wound Care Assessments and documentation, And Wound care Principles, Products And Protocols by 02/15/10. The Wound Care Specialist will conduct Ongoing audits on wound management (G-143)  Patients #1 #2 #3 see above G-143.		

accepted 1/19/10  
J. Demark



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G 172	<p>Continued From page 8</p> <p>assessments. As a result the patient's wound deteriorated, and the patient's family was forced to seek emergency medical care for the patient, who was admitted to the hospital on 06/23/09 with a wound infection. The physician hospital discharge summary documented the patient died on 07/13/09 with a primary diagnosis of infected right hip. Specifically:</p> <p>On 06/20/09 the Physical Therapist (PT) visited the patient and documented the patient was complaining of an odor from the right thigh (wound).</p> <p>On 06/21/09 a SN visited the patient and although she documented she discussed the signs and symptoms of infection with the patient, the SN failed to assess the wound, and failed to assess if the wound had a foul odor, as documented by the PT the prior day. Two days later, on 06/23/09, the hospital physician documented the patient was admitted with a large non healing ulcer of the right hip which had foul smelling drainage. The patient subsequently died on 07/13/09 as a result of cellulitis of the right hip ulcer, per the 07/13/09 death certificate.</p> <p>The patient record was reviewed with the agency Administrator and Acting Director of Patient Services on 12/03/09. No additional information was provided.</p> <p>2. Patient # 1 was admitted to the agency on 05/17/09. On 05/17/09 the SN documented in the initial nursing assessment the patient had 6 wounds on the left elbow. Although the SN visited 12 times between 05/22/09 and 07/06/09, the SN failed to ever reassess 5 of the 6 wounds.</p>	G 172					

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 12/03/2009
NAME OF PROVIDER OR SUPPLIER  GENTIVA HEALTH SERVICES BINGHAMTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1249 FRONT STREET, SUITE 110 BINGHAMTON, NY 13905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 172	<p>Continued From page 9</p> <p>The surveyor interviewed and reviewed the patient record with the Administrator and Acting Director of Patient Services on 12/03/09. No additional information was provided.</p> <p>3. Patient # 3 was admitted to the agency on 05/07/09. On 05/07/09 the SN documented in the initial nursing assessment the patient had a new wound on the right hand. Although the SN visited the patient 8 times between 05/07/09 and 05/29/09, the SN failed to ever reassess the wound.</p> <p>The surveyor interviewed and reviewed the patient record with the Administrator and Acting Director of Patient Services on 12/03/09. No additional information was provided.</p>	G 172			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/27/2009
NAME OF PROVIDER OR SUPPLIER  ST JOSEPHS HOSP HEALTH CENTER CHHA			STREET ADDRESS, CITY, STATE, ZIP CODE 7246 JANUS PARK DRIVE LIVERPOOL, NY 13088		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 000	<p>INITIAL COMMENTS</p> <p>The following statement of deficiencies represents the results of an extended survey of the agency's Certified Home Health Agency (CHHA) initiated on May 26, 2009.</p> <p>This survey was initiated as a complaint survey for complaints # NY00070260, NY00070248, NY00071439 on May 08, 2009. On May 26, 2009 it was identified that significant systemic problems with skilled nursing existed and the survey was converted to an extended level survey.</p> <p>As a result of the extended level survey, on May 28, 2009, deficient practices were identified at condition level in the following 4 Conditions of Participation: G 122 Organization, Services and Administration, G 156 Acceptance of Patients, Plan of Care, Medical Supervision, G 168 Skilled Nursing Services, G 242 Evaluation of the Agency's Program.</p> <p>The cumulative effect of these systemic problems resulted in the home care agency's failure to ensure the provision of quality health care, and in negative outcomes for 9 patients. Patients # 1, 3, 4, 10, 19, 20, 22, 23, 27, including 3 patient deaths. Patients # 3, 4, 27</p> <p>On 06/12/09 an additional complaint was received #NY00073108, and an on site investigation was included in this survey.</p> <p>A total of 27 clinical records were reviewed (1-26) including 10 observational home visits. Additionally reviewed during the survey were the agency's: OBQI Adverse Event Report for 02/2008 - 01/2009, policy and procedure manual; Professional Advisory Committee, and Governing</p>	G 000	<p>73108</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



8/11/09  
accepted  
HD

August 11, 2009

Lynn Shannon  
Nursing Service Consultant  
New York State Department of Health  
217 South Salina Street  
Syracuse, New York 13202

Dear Lynn:

Enclosed is the revised Plan of Correction developed for St. Joseph's Home Care Agency for the deficiency report from the survey conducted in May 2009.

Please do not hesitate to contact me at (315) 458-2800 if you have any questions or need further information.

Sincerely,

A handwritten signature in cursive script, reading "Cheryl Bowhall".

Cheryl Bowhall  
Director of Patient Services

CB/jlm  
Enclosures

CC: Mark Murphy  
Brenda Ko

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  ST JOSEPHS HOSP HEALTH CENTER CHHA			STREET ADDRESS, CITY, STATE, ZIP CODE 7246 JANUS PARK DRIVE LIVERPOOL, NY 13088		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 000	Continued From page 1 Body meeting minutes for the most recent twelve months; telehealth program; quality assurance program; complaint investigation log; contracts; emergency disaster plan, and 21 personnel records. Interviews were conducted with: the Director of Patient Services; Assistant Director of Patient Services, Quality Improvement Nurse, and agency staff.	G 000			
G 118	484.12(a) COMPLIANCE WITH FED, STATE, LOCAL LAWS  The HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations. If State or applicable local law provides for the licensure of HHAs, an agency not subject to licensure is approved by the licensing authority as meeting the standards established for licensure.  This STANDARD is not met as evidenced by: In 12 of 27 patient records reviewed, there is a lack of evidence that the agency is in compliance with all applicable Federal, State, and local laws and regulations. Specifically:  1. In 4 of 25 patient records reviewed where the patient was admitted after 11/01/08, the agency failed to visit the patient within 24 hours of receipt and acceptance of a community referral and/or return home from an inpatient facility per NYCRR 10, part 763.5 (a). Patients # 3, 20, 22, 26.  Failure to visit the patient within 24 hours of hospital discharge, or receipt of community referral has the potential for unmet patient needs, and possible negative wide patient outcomes.  Examples are as follows:	G 118	G118 Compliance with Federal, state and local laws  Agency Intake and scheduling RN's re-educated to accept referrals for service with a specified first visit date agreed upon by the referral source whenever the agency is not able to visit the next day. Education included: <ul style="list-style-type: none"><li>• Patient/caregiver knowledge and agreement with the change</li><li>• Communication to the ordering physician</li><li>• Communication to the referral source when deviation from the agreed upon plan occurs</li><li>• All communication to be documented in the patient's medical record.</li></ul> Completion date: July 1, 2009 Responsible person: Intake Manager M-F Supervising Nurses off shift DPS over all  See G250 for QA detail for monitoring		

*Accepted 8/11/09  
J. DeMartino*

NAME OF PROVIDER OR SUPPLIER

ST JOSEPHS HOSP HEALTH CENTER CHHA

STREET ADDRESS, CITY, STATE, ZIP CODE

7246 JANUS PARK DRIVE  
LIVERPOOL, NY 13088

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KVRW11

Facility ID: 5987

If continuation sheet Page 3 of 92

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NAME OF PROVIDER OR SUPPLIER

ST JOSEPHS HOSP HEALTH CENTER CHHA

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7246 JANUS PARK DRIVE  
LIVERPOOL, NY 13088

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G 118	Continued From page 3 visit would be scheduled for the next day. On 5/26/09 the SN failed to visit the patient, and the Patient Activity Log documented that the patient's wife called again to state that no one had shown up for her visit. The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 06/08/09. No additional information was provided.  - For patient # 20, the Patient Referral Summary form documented that the patient was discharged from the hospital on 11/26/08, and that the agency received a referral on 11/28/08. The SN failed to visit the patient until 11/30/08, which was 2 days after the referral, and failed to notify the physician. The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 06/08/09. No additional information was provided.  - For patient #3, the Patient Referral Summary form documented that the patient was referred to the agency on 11/3/08, the SN failed to visit the patient for the initial assessment until 11/05/08 which was 2 days after the referral, and the SN failed to notified the physician of the delay. The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 07/01/09. No additional information was provided.  2. In 10 of 27 patient records reviewed, there is a lack of evidence that the agency is in compliance with all applicable Federal, State, and local laws and regulations. Specifically:  There is no evidence in 10 of 21 patient records reviewed, where the patient was on service for greater than 30 days, that the plans of care were	G 118		
			Patient #20 has been discharged from the agency.  Patient #3 has been discharged from the agency.        Patient #4 has been discharged from the agency.   Patient #8: current plan of care signed within 30 days.  Patient #23: Current plan of care signed within 30 days.	

*Accepted 8/11/09*  
*A. Demetriou*

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NAME OF PROVIDER OR SUPPLIER

ST JOSEPHS HOSP HEALTH CENTER CHHA

STREET ADDRESS, CITY, STATE, ZIP CODE

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LIVERPOOL, NY 13088

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G 118	Continued From page 4 signed by the physician within 30 days after admission to the agency Per NYCRR 10 part 763.7 (a) (3) (i) Patients # 3, 4, 5, 6, 7, 8, 14, 23, 24, 27  Failure to have the physician sign the plan of care within 30 days has the potential of unmet patient needs, and possible negative patient outcomes.  Examples are as follows:  - Patient # 4 was admitted to the agency on 12/05/09. The agency failed to obtain a physician's signature on the 12/05/09 plan of care until 01/29/09.  - Patient # 8 was admitted to the agency on 04/10/09. The agency failed to obtain a physician's signature on the 04/10/09 plan of care until 05/15/09.  - Patient # 23 was admitted to the agency on 04/03/09. The agency failed to obtain a physician's signature on the 04/03/09 plan of care until 06/05/09, which was 61 days.  The above records were reviewed on 06/03/09, 06/03/09, and 06/09/09 with the DPS and ADPS. No additional information was provided.	G 118	Agency policy and procedure for obtaining signatures on patient Plans of Care within a 30 day time frame was updated to include:  <ul style="list-style-type: none"> <li>Medical record staff tracking of orders by number of days old</li> <li>Medical record staff notify Supervising Nurse of delay for follow-up and resolution with the physician as soon as a problem is identified or if order not returned by day 27</li> <li>Supervising nurse to work with Case Manager to resolve</li> <li>Medical record staff to notify DPS whenever no response from Supervising Nurse within 48 hrs. of notice of problem obtaining MD signature</li> <li>Communication of follow-up by the supervising nurse is to be documented in the medical record</li> </ul> Completion date: July 1, 2009. Responsible person: Medical Records Coordinator Supervising Nurses DPS  SEE G250 for QA detail to monitor  <i>Accepted 8/11/09</i> <i>H De Martine</i>	
G 122	484.14 ORGANIZATION, SERVICES & ADMINISTRATION  This CONDITION is not met as evidenced by: o Failure to identify patients who have the potential to develop negative outcomes and failure to implement systems and interventions			



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NAME OF PROVIDER OR SUPPLIER  ST JOSEPHS HOSP HEALTH CENTER CHHA	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 JANUS PARK DRIVE LIVERPOOL, NY. 13088
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G 122	<p>Continued From page 5</p> <p>designated to the prevention of those negative outcomes. G140,143,168</p> <p>o Failure of the governing body to assume responsibility for the overall management of the agency. G128</p> <p>o Failure to ensure administrative and supervisory functions are performed effectively and that agency policies and procedures are appropriate and implemented consistently G133,140</p> <p>o Failure to develop and implement a system which ensures that changes in patient condition are promptly identified and reported to the physician, and that priority needs are addressed, both of which are necessary to the prevention of negative patient outcomes. G 164</p> <p>o Failure to ensure effective communication and coordination between all disciplines including supervisory staff as outlined in agency policy. G143,144</p> <p>o Failure to ensure internal quality assurance/improvement audits are of sufficient scope to identify quality of care issues, that results are trended, and that adequate plans are being developed and revised for the resolution of identified problems. G250</p> <p>The cumulative effect of these systemic problems resulted in the home care agency's failure to ensure the provision of quality health care. Additionally, this failure to provide oversight resulted in negative outcomes for 9 patients (patients # 1, 3, 4, 10, 19, 20, 22, 23, 27, including 3 patient deaths (patients # 3, 4, 27)</p>	G 122	<p><b>G122 Organization, Services, and Administration</b></p> <p>See G133 for Administrator communication to governing body</p> <p>See G140 for reorganization of supervision,</p> <p>See G143 for Coordination of Care</p> <p>See G250 for QA detail</p> <p><i>Accepted 8/11/09 H. Demetrio</i></p>	

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LIVERPOOL, NY 13088

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G 122	Continued From page 6 and has resulted in the agency's failing to ensure all patient needs are identified and met, and has the potential for negative outcomes for the agency's entire patient population.	G 122		
G 128	484.14(b) GOVERNING BODY  A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.  This STANDARD is not met as evidenced by: Based on a review of 27 clinical records, review of Professional Advisory Committee (PAC) meeting minutes, and Governing Body meeting minutes, and interviews with the Director of Patient Services (DPS), and Assistant Director of Patient Services (ADPS), and agency staff, evidence is lacking in 26 records the governing body effectively oversees the operation and management of the agency. Patients # 1 - 8, 10 - 27  Failure of the Governing Body to provide adequate oversight and direction of the agency resulted in negative patient outcomes for patients # 1, 3, 4, 10, 19, 20, 22, 23, 27, including 3 patient deaths-(patients # 3, 4, 27), and has resulted in the agency failing to ensure all patient needs are identified and met, multiple repeat standard level deficiencies, and multiple condition level deficiencies as outlined in the body of this report.  Specifically, evidence is lacking that the following Governing Body responsibilities are being performed:  o Exercising its overall management and	G 128	<b>G128 Governing Body</b>  See G118 for compliance with Federal, State and Local law  See G133 for Administrator communication to Governing Body  See G140 for enhanced supervision  See G143 and G144 for care coordination  See G250 for QA detail  The Administrator communicated survey results, including negative outcomes, Condition level citations, Condition survey process to the governing body. Board Members will provide operational oversight and direction to the agency via the Administrator. Ongoing evidence of oversight will be documented in Board Executive Committee and Board of Director minutes.  Completion date: July 30, 2009 Responsible person: Board Chair  The Executive Committee of the Board of Directors will receive and review monthly Professional Advisory Committee reports with the Administrator. The Administrator will review audit trends for areas of improvement and  <i>accepted 8/11/09</i> <i>J. Demontre</i>	

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NAME OF PROVIDER OR SUPPLIER  ST JOSEPH'S HOSP HEALTH CENTER CHHA	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 JANUS PARK DRIVE LIVERPOOL, NY 13088
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G 128	Continued From page 7 supervision of the agency. There is insufficient evidence that the Governing Body understood its responsibility to provide oversight and direction to the agency.  Specifically, the Governing Body failed to ensure that the PAC conducted an Annual Agency Evaluation in the past 12 months, and failed to consistently review problems identified by the Quality Improvement Committee, and the action plans developed by the PAC committee to resolve problems. Specifically, although the Governing Body's Executive Committee met on 07/25/08, 12/05/08, and 01/30/09 the Executive Committee Meeting Minutes failed to include any discussion of the agency's Quality Improvement program until the 03/27/09 meeting. See G 243, G 250  o Ensuring that supervision of all patient care is provided and readily available. Specifically that: case coordination is being performed; plans of care are complete and being implemented; physicians are consulted in plan of care development, changes in patient condition are being reported to the physician; nursing assessments are complete and accurate; See G 140, G 143, G 144, G 158, G 159, G 160, G 164  o Ensuring that services provided are of sufficient quality to meet the needs of its patient population. See G 171, G 172  o Ensuring that the agency is in compliance with all state and local laws. G 118	G 128	corresponding Action Plans, new, revised, and reviewed policies, as well as survey and Plan of Correction updates to the committee each month. Any/all systemic issues identified during or post survey will also be presented, with a plan of correction, and request for discussion by and guidance from Committee Members.  A full report will be provided to the Board of Directors by the Administrator at three times a year. The Board of Directors will provide operational oversight and direction to the Agency Administrator as information and data trends dictate. Evidence of compliance will be documented in Executive Committee and Board of Director meeting minutes.  Completion date: August 28, 2009 Responsible person: Board Chair Administrator	
G 133	484.14(c) ADMINISTRATOR  The administrator, who may also be the supervising physician or registered nurse required	G 133		

*Accepted 8/11/09*  
*H. Demetriou*

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G 133	<p>Continued From page 8</p> <p>under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.</p> <p>This STANDARD is not met as evidenced by: Based on: review of 27 clinical records, 10 observational home visits, interviews with the Administrator, Director of Patient Services (DPS), Assistant Director of Patient Services (ADPS), and agency staff, review of personnel records, agency policy and procedures, minutes of the Professional Advisory Committee, governing body meeting minutes; evidence is lacking in 26 records the Administrator effectively oversees the operation and management of the agency. Patients # 1 - 8, 10 - 27</p> <p>Failure of the Administrator to provide adequate oversight and direction of the agency resulted in negative outcomes for patients # 1, 3, 4, 10, 19, 20, 22, 23, 27, including 3 patient deaths (patients # 3, 4, 27), and has resulted in the agency failing to ensure all patient needs are identified and met, and has the potential for negative outcomes for all patients served by the agency.</p> <p>Specifically, evidence is lacking the following responsibilities of the Administrator are being performed:</p> <ul style="list-style-type: none"> <li>o Ensuring the Governing Body is aware, and kept informed of the significant, systemic problems that existed with skilled nursing, which the agency has been unable to resolve, as outlined in this report. See G 143, G 158, G159, G 160, G164, G171, G172</li> </ul>	G 133	<p><b>G133 Administrator</b></p> <p>See G128 for Administrator communication to the Governing Body</p> <p>See G140 for reorganization of Supervisory duties</p> <p>See G143 for Coordination of Care detail</p> <p>See G168 for education provided to Skilled Nurses</p> <p>See G250 for QA detail</p> <p>The Administrator will continue to be a member of the PAC and Executive Committee of the Board of Directors, and will keep the Board informed of agency operations monthly including, but not limited to:</p> <ul style="list-style-type: none"> <li>• Review of PAC reports</li> <li>• Occurrence and complaint trending</li> <li>• Outcome trends</li> <li>• Clinical audit findings</li> <li>• Survey updates</li> <li>• Presentation and updates regarding changes to and results of Action Plans</li> </ul>	

*accepted 8/11/09  
J. DeMartino*

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G 133	Continued From page 9 o Ensuring internal quality improvement audits provided to the governing body are of sufficient scope to identify the areas in need of improvement, and that adequate action plans are developed to correct areas in need of improvement. See G 243, G250  o Ensuring the provision of adequate supervision of patient care and skilled nursing staff. Specifically, that supervising nurses are fulfilling the responsibilities as outlined in the agency's job description, specifically: case coordination is being performed; plans of care are complete and being implemented; changes in patient condition are being reported to the physician; nursing assessments are complete, accurate, and timely. G 118, G 140, G 143, G 144, G 158, G 159, G 160, G 164, G 171, G 172	G 133	that address areas identified for improvement  Completion date: 8/28/09 Responsible person: Administrator  The Administrator will: <ul style="list-style-type: none"><li>• Have consistent/ongoing contact with the DPS or covering RN</li><li>• Meet with the DPS bi-weekly</li><li>• Be available or have an alternate available to the agency 24/7</li></ul> Evidence of Administrator compliance will be found in minutes of bi-weekly meeting with DPS.  Completion date: July 28, 2009 Responsible person: Administrator	
G 140	484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE  Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).  This person, or similarly qualified alternate, participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.  This STANDARD is not met as evidenced by: Based on a review of 27 clinical records, and interviews with the Director of Patient Services (DPS), Assistant Director of Patient Services (ADPS), Quality Improvement Nurse, and agency		<i>Accepted 8/11/09 J. Romo</i>	

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CMS NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/27/2009
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NAME OF PROVIDER OR SUPPLIER

ST JOSEPHS HOSP HEALTH CENTER CHHA

STREET ADDRESS, CITY, STATE, ZIP CODE

7246 JANUS PARK DRIVE  
LIVERPOOL, NY 13088

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G 133	Continued From page 9 o Ensuring internal quality improvement audits provided to the governing body are of sufficient scope to identify the areas in need of improvement, and that adequate action plans are developed to correct areas in need of improvement. See G 243, G250  o Ensuring the provision of adequate supervision of patient care and skilled nursing staff. Specifically, that supervising nurses are fulfilling the responsibilities as outlined in the agency's job description, specifically: case coordination is being performed; plans of care are complete and being implemented; changes in patient condition are being reported to the physician; nursing assessments are complete, accurate, and timely. G 118, G 140, G 143, G 144, G 158, G 159, G 160, G 164, G 171, G 172	G 133	Mandatory interactive staff meeting held by Administrator. Education and discussion included:  <ul style="list-style-type: none"> <li>• Survey results</li> <li>• What Condition level survey entails</li> <li>• Negative patient outcomes</li> <li>• Cause of negative outcomes, i.e. lack of case management, omission of care/interventions as appropriate to patient need, lack of supervision, inadequate communication amongst clinicians, physicians, supervisors, lack of problem follow-up, lack of safety management planning, lack of adherence to agency policy, procedure and standards</li> <li>• The goal to succeed</li> <li>• Commitment to success and return to excellence</li> <li>• Staff expectations of performance</li> <li>• Supervisory enhancements</li> <li>• Addition of new clinical Team</li> <li>• Addition of Scheduling Manager</li> <li>• Upgrade of RD position from .5 to 1.0 FTE</li> <li>• Agency focus on patient care and staff performance</li> <li>• Increased objective auditing, care oversight</li> <li>• Readmission reviews</li> </ul>	
G 140	484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE.  Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).  This person, or similarly qualified alternate, participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.  This STANDARD is not met as evidenced by: Based on a review of 27 clinical records, and interviews with the Director of Patient Services (DPS), Assistant Director of Patient Services (ADPS), Quality Improvement Nurse, and agency			

*Accepted 8/11/09  
A. Demetrius*

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  ST JOSEPHS HOSP HEALTH CENTER CHHA			STREET ADDRESS, CITY, STATE, ZIP CODE 7246 JANUS PARK DRIVE LIVERPOOL, NY 13088		
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G 133	Continued From page 9 o Ensuring internal quality improvement audits provided to the governing body are of sufficient scope to identify the areas in need of improvement, and that adequate action plans are developed to correct areas in need of improvement. See G 243, G250 o Ensuring the provision of adequate supervision of patient care and skilled nursing staff. Specifically, that supervising nurses are fulfilling the responsibilities as outlined in the agency's job description, specifically: case coordination is being performed; plans of care are complete and being implemented; changes in patient condition are being reported to the physician; nursing assessments are complete, accurate, and timely. G 118, G 140, G 143, G 144, G 158, G 159, G 160, G 164, G 171, G 172	G 133	<ul style="list-style-type: none"> <li>Increased review of at risk patients</li> <li>Necessity and function of appropriate Case Management and coordination of care</li> <li>Std of care and assessment expectations clarified</li> <li>Accountability to patient care</li> </ul> <p>Completion date: July 30, 2009 Responsible person: Administrator</p> <p><i>Accepted 8/11/09</i> <i>At Demand</i></p>		
G 140	484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE  Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).  This person, or similarly qualified alternate, participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.  This STANDARD is not met as evidenced by: Based on a review of 27 clinical records, and interviews with the Director of Patient Services (DPS), Assistant Director of Patient Services (ADPS), Quality Improvement Nurse, and agency				

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G 140	<p>Continued From page 10</p> <p>staff, evidence is lacking in 26 records (patient # 1 - 8, 10 - 27) that supervisory responsibilities are being performed.</p> <p>Failure of the DPS, ADPS and Supervising Nurses to provide adequate oversight and direction of the agency resulted in negative outcomes for patients # 1, 3, 4, 10, 19, 20, 22, 23, 27, including 3 patient deaths (patients # 3, 4, 27), and has resulted in the agency failing to ensure all patient needs are identified and met. This has the potential for negative outcomes and unmet needs for all patient's being served by the agency.</p> <p>Specifically, the following supervisory functions were not being performed:</p> <ul style="list-style-type: none"> <li>- Ensuring that initial nursing assessments are conducted within the proper time frame, and plans of care are developed, in compliance with NYCRR 10. See G118</li> <li>- Ensuring that SNs are fulfilling all responsibilities as outline in the agency's job description, specifically, case management, case coordination, developing and implementing plans of care, performance of initial and ongoing assessments, supervision of paraprofessionals. See G 143, G 158, G159, G 171, G 172, G 229.</li> <li>- Ensuring that Supervising Nurses are aware of the current status of each patient; that skilled nurses are providing comprehensive patient assessments and reassessments; that the plan of care developed is comprehensive and meets all patient needs. G144, G 159, G 171, G 172</li> <li>- Ensuring that coordination/case management is</li> </ul>	G 140	<p><b>G140 Supervising physician or registered nurse</b></p> <p>See G250 for QA details</p> <p>Clinical supervisory structure reorganized. Supervising nurses report to DPS. Weekly meetings with DPS and supervising nurses instituted. Supervising nurse responsibilities and expectations clarified as follows:</p> <ul style="list-style-type: none"> <li>• Weekly 1:1 Case reviews with Case Management staff with review documented in the patients medical record</li> <li>• Direct receipt of report from field staff for SOC, ROC's, Recerts and changes in patient condition</li> <li>• Supervision of Case Management staff in the development of the Plan of Care, including obtaining physician authorization for services at least weekly</li> <li>• Supervision of Case Management staff in appropriate Case Management of assigned patients at least weekly</li> <li>• Active involvement in coordination of care with agency staff, external providers, physicians to assure problem resolution</li> <li>• Assuring staff accountability for adherence to agency policy, procedure and standards of care</li> <li>• Prompt and thorough occurrence and complaint follow-up and documentation</li> <li>• Communication to DPS re: any significant event, concern</li> </ul>	

*Accepted 8/11/09  
J. DeMartino*



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G 140	Continued From page 11 being performed consistently and that all pertinent patient information is communicated to all individuals providing care, and documented in the clinical record. See G 143  - Ensuring that the agency's professional staff promptly alerts the physician to any changes in the patient's condition that may suggest a need to alter the plan of care. See G 164  - Ensuring that plans of care are developed in consultation with the physician, and that the plans of care are being implemented. See G 143, G 158, G 160  On 06/09/09 the Director of Patient Services (DPS) stated to the surveyor that patient case conferences between the Skilled Nurses and the Supervising Nurses are to occur every 1-2 weeks. Evidence is lacking the case conferences are being conducted every 1-2 weeks, and/or that the Supervising Nurses are identifying unmet patient needs during the patient conferences. This resulted in negative outcomes for patients # 3, 4, 10, 20, 27. See G 140, G 143  Additionally, although there is evidence the ADPS and Supervising Nurses were reviewing patient records of patients at the start of care, evidence is lacking the problems identified by this survey are being identified by the Supervising Nurses and ADPS.	G 140	Addition of Support RN provided to each supervising nurse. Role clarification documented and placed in each Supervising nurses HR file.  Completion date: June 5, 2009 Responsible person: DPS Supervising Nurses  DPS-Supervising Nurse meetings being minuted to document weekly DPS supervision.  Completion date: July 14, 2009 Responsible person: DPS  Reorganization of the Agency Performance Improvement Department with the addition of the ADPS for departmental oversight and supervisory responsibilities of agency PI/QA activities r/t survey, to include: <ul style="list-style-type: none"><li>• audit activities to include focused wound, nutrition, and diabetic patient auditing</li><li>• Week to week trending of audit findings to concurrently identify and respond to deficient areas</li><li>• Plan for individual clinician follow-up and remediation, discipline as approp.</li><li>• Development of Action Plans specific to each deficient area. Action plans to include ongoing monitoring and Plan for revision to Action Plans as audit trends dictate</li><li>• Plan for agency education targeted areas identified as deficient</li></ul>	
G 143	484.14(g) COORDINATION OF PATIENT SERVICES  All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.		Completion date: August 10, 2009 Responsible person: Administrator DPS	

accepted 8/11/09  
J. Domantow

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G 143	484.14(g) COORDINATION OF PATIENT SERVICES  All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.			

*Accepted 8/11/09*  
*H Demas*

12A

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G 143	484.14(g) COORDINATION OF PATIENT SERVICES  All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.			

Completion date: June 19, 2009  
Responsible person: ADPS

*accepted 8/11/09*  
*Handwritten signature*

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G 143	484.14(g) COORDINATION OF PATIENT SERVICES  All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.		accepted 8/11/09 H DeMartino	

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G 143	484.14(g) COORDINATION OF PATIENT SERVICES  All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.		<p>Completion date: July 24, 2009 Responsible person: DPS</p> <p>DPS performed detail review of survey SOD with collective counseling of all Supervising Nurses. Discussion included failure and shortcomings of supervisory function and structure in oversight of care provided to agency patients, and resultant negative patient outcomes. Clarification of job duties and expectations focusing Supervising Nurses on the management of staff and patient care, with the expectation of self and staff accountability to the provision of quality care in accordance with agency policy, procedure and stds and all applicable federal, state and local law and regulation, and prompt communication of issues and concerns to DPS. Discussion documented in meeting minutes.</p>	

*Accepted 8/11/09  
H. Remane*

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G 143	484.14(g) COORDINATION OF PATIENT SERVICES  All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.		Completion date: August 6, 2009 Responsible person: DPS  <i>Accepted 8/11/09</i> <i>H. Demantre</i>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337241	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED  07/27/2009
NAME OF PROVIDER OR SUPPLIER  ST JOSEPHS HOSP HEALTH CENTER CHHA			STREET ADDRESS, CITY, STATE, ZIP CODE 7246 JANUS PARK DRIVE LIVERPOOL, NY 13088		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 143	<p>Continued From page 12</p> <p>This STANDARD is not met as evidenced by: Based on a review of 27 clinical records and review of agency policies and procedures, and interviews with the Director of Patient Services (DPS) and Assistant Director of Patient Services (ADPS), there is no evidence in 17 records, that the skilled nurses (SN) are consistently functioning in the role of case management/case coordination, or that they have a clear understanding of the role of the home care nurse in providing case management coordination. Patients # 2 - 5, 7, 8, 10 - 12, 14 - 18, 20, 24, 27</p> <p>Lack of adequate case management and case coordination has resulted in negative outcomes for patients # 3, 4, 10, 20, 27, including 3 patient deaths Patients # 3, 4, 27, and has the potential for agency wide unmet patient needs and negative patient outcomes. Patient # 20 was identified on the OBQI Adverse Events Outcome Report for 2/2008 - 1/2009 for emergent hospitalization resulting from a fall.</p> <p>Examples are as follows:</p> <p>1. Patient # 27 was admitted to the agency on 09/09/08. On 03/06/09 the Skilled Nurse (SN) conducted a comprehensive recertification nursing assessment. The 03/08/09 updated plan of care included a primary diagnosis of open wound, and included SN visits 2 times per week for 8 weeks for wound care, foley catheter maintenance, and assessment.</p> <p>Although the patient called the agency for help on 04/27/09, the agency failed to follow up with the patient. Two days later, on 04/29/09 the patient</p>	G 143	<p><b>G143 Coordination of patient services</b></p> <p>See G140 for enhanced Supervision</p> <p>See G168 for Skilled Nurse education</p> <p>See G250 for QA detail</p> <p>Record review and case presentation were held with all agency caregivers having provided care to patients #1,3,4,10,19,20,22,23,27 identified in the statement of deficiencies. Areas discussed included:</p> <ul style="list-style-type: none"> <li>• Case overview</li> <li>• Identified areas of deficiency that led to negative outcome</li> <li>• interventions/care/care coordination that would have improved the patient situation and/or mitigated the negative outcome</li> <li>• Plan of Care development and following or altering the Plan of Care as approp.</li> <li>• Notifying the physician to barriers to the Plan of Care, changes in patient condition and need to alter the Plan of Care</li> <li>• Appropriate case management for each individual patient</li> <li>• Re-education to agency policy, procedure and stds applicable to each case</li> </ul>		

Patient #27 has been discharged from the agency.

*accepted 8/11/09*  
*J. Demarino*

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G 143	<p>Continued From page 13</p> <p>was found on the floor by a lab technician who was assigned to draw blood. The patient was transported to the hospital by 911 responders. The patient had been pinned to the floor at home for 2 days, despite having called the agency for help on 04/27/09.</p> <p>The patient subsequently died on 06/10/09. The 06/10/09 hospital physician discharge summary upon the patient's death stated "Chief Complaint: Difficulty breathing....The patient's difficulty breathing apparently began about a month ago in association with her falling at home. The patient was down for approximately 40 hours, and was unable to get up...the patient deceased on 06/10/09"</p> <p>Specifically:</p> <ul style="list-style-type: none"> <li>- The 04/29/09 admitting history and physical by the hospital physician documented that on the night of 04/27/09 the patient felt weak, and she had fallen to the floor, "She was unable to get up...she lives alone in an apartment... she was yelling all day Tuesday (04/28/09)...she was unable to get to the phone...she remained on the floor until Wednesday morning (04/29/09)...she was also weak Sunday (04/26/09) night and fell, requiring the fire department to come help her.</li> <li>- The 04/29/09 emergency medical services record documented that the patient: "had been lying on the bedroom floor for 2 days... had a dresser drawer across her thigh... was confused... had a cyanotic face." The 04/29/09 note by the hospital physician also documented the patient was admitted with "pneumonia, dehydration, acute renal failure, urinary tract infection, weakness...."</li> </ul>	G 143	<p>Staff involved in each case were counseled as approp. regarding performance, and expectation of adherence to Agency policy, procedure and stds of care. Applicable policy, procedure and stds were reviewed. Case Managers of patients #3 and 4 terminated and reported to OPD.</p> <p>Completion date: 08/10/09 Responsible person: DPS ADPS PI Coordinator</p> <p>Records of patients reviewed during survey who remain open to the agency were also reviewed by the Performance Improvement Coordinator and/or consulting RN. Review findings, both positive and deficient, were documented and provided to Supervising Nurses for appropriate patient follow-up and issue resolution, and clinician remediation and re-education as appropriate.</p> <p>Completion date: 08/10/09 Responsible person: ADPS</p> <p>Development and implementation of an On-call patient change in condition report for increased supervision for all supervisory staff for review to identify patient issues since prior shift for follow-up as needed.</p> <p>Completion date: May 13, 2009 Responsible person: DPS Supervising Nurses</p>		

*accepted 8/11/09*  
*if remediate*



## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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G 143	<p>Continued From page 14</p> <p>The SN failed to fulfill her role as case manager, and failed to:</p> <ul style="list-style-type: none"> <li>- coordinate and implement a plan of care which met the patient's ongoing safety needs, including the patient's ability to call for help in an emergent situation</li> <li>- coordinate necessary and life saving emergency medical services on 04/27/09</li> <li>- report the changes in patient condition to the physician.</li> </ul> <p>Specifically:</p> <ul style="list-style-type: none"> <li>- The SN failed to adequately assess the patient's safety needs, and coordinate and implement a safety plan for the patient. Specifically, on 03/06/09 the SN case manager documented that the patient was at risk for falls, could not be left alone, was confused, and had impaired decision making. The SN failed to document who was living with the patient, and on 03/27/09 the LPN visited the patient and documented that the patient was living alone. Although the SN case manager, and 4 other SNs visited the patient 10 times between the dates of 03/06/09 and 04/23/09, and all documented at every visit that the patient was not safe alone, the SN failed to coordinate a safety plan to address the patient's unmet safety needs, including contacting the patient's daughter, physician, and if necessary, Adult Protective Services, to ensure the patient was not being left alone unsafely.</li> </ul> <p>On 07/09/09 2 surveyors interviewed the SN case manager. The case manager stated that she was aware the patient lived alone, and felt that this was safe. The surveyor asked the SN why there</p>	G 143		

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G 143	<p>Continued From page 15</p> <p>was a contradiction between what she is saying and what she documented in the record. The SN stated that she had documented that the patient could not be left alone due to a computer error. However, the SN documented in 3 separate areas of the 03/06/09 nursing note, including a section which specified "homebound problems", as well as 3 subsequent nursing visit notes (03/10/09, 03/17/09, 03/24/09), that the patient was not safe to be left alone. Additionally, 3 other SNs visited the patient on 03/13/09, 03/27/09, 03/31/09, 04/06/09, 04/17/09, 04/21/09, 04/23/09, and all documented the patient was not safe at home alone.</p> <p>- The SN failed to coordinate a plan for Home Health Aide (HHA) services to meet the patient's safety and personal care needs. Specifically, on 03/06/09 the SN case manager documented in the comprehensive assessment the patient: was confused, had impaired decision making, required assistance with bathing, and dressing, had a privately hired aide. The SN failed to assess if the patient's needs were being met by the privately hired caregiver and family, or if the agency needed to provide additional HHA services to meet the patient's needs.</p> <p>During the 07/09/09 interview with the SN case manager, the SN stated to the surveyors: she was sure the patient's needs were being met by the private caregiver, because the patient "had told her so", she did not know why the agency was not providing a HHA for the patient because that had been determined prior to her taking over as the case manager (on 03/02/09). The SN failed to identify that it was her responsibility as the case manager to assess if all of the patient's needs were being met, including if the patient</p>	G 143			

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G 143	<p>Continued From page 16</p> <p>required HHA services from the agency, and discussing it with the patient's daughter if necessary. Instead the SN relied on the patient, who was confused, and had impaired decision making, to make this determination.</p> <p>On 07/13/09, the surveyor interviewed the patient's daughter. The daughter told the surveyor that the agency had never offered the services of a HHA, and that if they had been offered, she and her mother would have "most definitely" accepted them.</p> <p>- The SN failed to identify that the patient required a wheelchair for mobility, until the patient's 04/27/09 phone call to the agency, when the patient reported that she could not transfer from the toilet to the wheelchair.</p> <p>- The SN failed to coordinate a plan to ensure the patient was able to call for help if needed, and for the possible need of a Personal Emergency Response System (PERS). On 10/06/08 the social worker visited the patient and documented that the patient had a PERS, and on 03/06/09 the SN case manager documented that the patient was able to walk only with the supervision or assistance of another person at all times, could transfer herself, had a fear of falling. The SN case manager failed to assess how the patient was able to mobilize when the private caregiver was not present, assess if the patient had a PERS, and if so, if the patient was able to use it properly.</p> <p>On 07/09/09 2 surveyors interviewed the social worker and the SN case manager. The social worker stated she could not remember how she identified that the patient had a PERS, or if she</p>	G 143		

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G 143	<p>Continued From page 17</p> <p>had discussed it with the SN. The SN case manager stated she did not know if the patient had a PERS, but thought that the patient "would have probably activated it, if she had one, the night of her fall".</p> <p>On 07/13/09 the surveyor interviewed the patient's daughter. The daughter stated that the patient did not have a PERS, and that the patient wore her cordless phone around her neck. The SN failed to ever assess: the patient's ability to call for help if needed, if the phone placed around the patient's neck was a safe plan, if the patient was able to use the phone appropriately in the event of an emergency, and if the patient was conscientious about keeping it charged and within reach at all times.</p> <p>- The SN failed to coordinate and ensure that the patient received life saving emergency medical services when the patient called the agency reporting she was "stuck on the toilet", even after the patient reported to the nurse that she had fallen the night before. As a result the patient helplessly remained on the floor for two days after falling, unable to take her medications, including insulin and anticoagulant therapy, eat, or drink.</p> <p>On 04/27/09 at 4:30 PM the SN case manager documented in the Patient Activities Log that the patient called to report she was stuck on the toilet, and had been trying to get to her wheelchair for 2 1/2 hours. The SN instructed her to call 911, and the patient replied that she just called them the prior night after falling. The patient agreed to call 911, and the SN told the patient "we would place call this evening to follow up." The SN documented that she reported the situation to the evening coordinating RN.</p>	G 143		

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G 143	<p>Continued From page 18</p> <p>Both the SN case manager, and SN evening coordinator failed to ever follow up with the patient, and 2 days later, on 04/29/09 the patient was found on the floor by a lab technician, and was admitted to the hospital.</p> <p>During the 07/09/09 surveyors interview of the SN case manager, the surveyor asked the SN case manager why she had never followed up with the patient. The SN stated that on the morning of 04/28/09 she had called the hospital, and was told the patient had been admitted. When the surveyor questioned why the SN waited until the next morning to follow up, the SN then stated that she must have called the hospital the evening before. However, both the hospital emergency room and admitting physician's notes, as well as the emergency services record document that the patient had been on the floor in her apartment for 2 days, (since 04/27/09). The SN could not recall which hospital she phoned, and on 07/13/09 the patient's daughter told the surveyor she was certain the patient was not in the hospital on 04/27/09 or 04/28/09.</p> <p>On 07/09/09 the surveyors interviewed the evening SN coordinator. Although the SN case manager documented on 04/27/09 that she had reported that the patient was unable to get off the toilet to the evening SN coordinator, the SN coordinator stated she could not recall if she had discussed the patient's unsafe status with the SN case manager, or if she ever called the patient to follow up.</p> <p>- There is no evidence the SN reported to the physician that the patient had fallen. Specifically, on 04/27/09 the SN documented in the Patient</p>	G 143		

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G 143	Continued From page 19 Activity Log that in addition to her immediate problem of not being able to transfer herself from the toilet, the patient had also reported falling on the night of 04/26/09.  The patient record was reviewed with the Administrator, DPS, ADPS, and Supervising Nurse on 07/16/09. The DPS submitted the SN case manager's cell phone log for 04/27/09 and 04/28/09. The log contained 5 phone calls to the patient. Four of the phone calls were for 1 minute, and 1 call was for 2 minutes. The DPS stated that during the 2 minute phone call at 10:38 AM, the SN case manager spoke to the patient, and the patient declined a visit.  On 07/17/09 the surveyor interviewed the patient's daughter. The daughter stated that there were 2 phone messages from the agency on 04/28/09, one of which was from the SN case manager at approximately 10:30 AM. The message was detailed, and included the case manager stating that she was in the lobby (of the patient's apartment building), and that she spoke to people at the front desk. They said that they had seen you (the patient), and that you are fine.  Additionally, the daughter stated that the agency was aware that the door of the patient's apartment was always left open to allow access for all caregivers, and that she had instructed the agency to visit the patient, whether or not she answers the phone. During the 07/09/09 interview by the surveyor of the SN case manager, the case manager also stated the patient left the door propped open.  2. Patient #3 was admitted to the agency on 11/05/08. The 11/05/08 plan of care included SN	G 143		
			Patient #3 has been discharged from the agency.	

*Accepted 8/11/09  
H. Demetrius*

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G 143	<p>Continued From page 20</p> <p>visits 2 times per week for 2 weeks, 1 time per week for 1 week, and 3 as needed visits. The 01/04/09 plan of care included SN visit 1 time per month for 2 months, and 2 as needed visits. Both plans specified that the SN was to: assess for medication effectiveness and compliance with medication regiment, skin integrity, neurological status, change the patient's foley catheter every month.</p> <p>The SN failed to understand her role as case manager, and failed to:</p> <ul style="list-style-type: none"> <li>- develop and coordinate an ongoing plan of care which met the patient's needs</li> <li>- coordinate the plan of care with the physician</li> <li>- provide adequate oversight and supervision to the primary caregiver to ensure the patient's needs were met</li> <li>- recognize changes in the patient's condition and report these changes to the physician.</li> </ul> <p>As a result, the patient's condition deteriorated significantly, and the patient was admitted to the hospital on 02/02/09, and subsequently died in a Skilled Nursing Facility on 03/08/09. The 02/02/09 emergency medical services record, and hospital emergency room record documented that the patient was admitted with lice and bedbugs, covered in feces, and had a stage 2 sacral decubitus. The hospital record also documented that the patient was severely hypothyroid, and the Primary Care Physician (PCP) documented on 02/05/09 that the patient was emaciated with an approximate weight loss of 50 - 60 lbs.</p> <p>Although the SN visited the patient 7 times between 11/05/08 and 01/13/09, the SN failed to:</p>	G 143			

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G 143	<p>Continued From page 21</p> <p>- coordinate a plan of care with the physician. Although the initial referral came from the urologist, the urologist was unwilling to take responsibility for the patient, and neither would the PCP. The agency inappropriately admitted the patient without securing physician authorization. Specifically, the Clinical Episode Documents form in the electronic record documented that on 11/10/08, 01/12/09, and 01/26/09 the agency called the urologist, who refused to sign the plan of care; and on 11/05/08 and 01/04/09 the agency called the PCP, who refused to sign the plan of care.</p> <p>Additionally, on 11/03/08 the agency documented that the PCP would not take responsibility for the patient because she had not seen the patient in over 1 month. The SN failed to coordinate a plan that included the patient being seen by the PCP at the start of care, or identify that the agency could not admit the patient, or continue to provide services without a supervising physician.</p> <p>The PCP's progress notes stated that the patient had not been seen by the PCP since 08/13/08, and between the dates of 09/29/08 and 01/16/09 the patient had missed 10 appointments.</p> <p>On 5/27/09 the surveyor interviewed the SN case manager. The SN stated that she was not aware that the patient's plan of care had not been signed by a physician for 2 certification periods (4 months), that the patient had missed 9 visits with his PCP and had not been seen since his admission to the agency.</p> <p>- ensure that the patient and primary caregiver were able to independently administer the patient's medications correctly per the plan of</p>	G 143		



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LIVERPOOL, NY 13088

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G 143	<p>Continued From page 22</p> <p>care. The 11/05/08 plan of care included 10 medications, including synthroid (thyroid hormone replacement) 25 mcg daily. The 11/05/08 initial nursing assessment documented that the patient and caregiver required repeat instruction for medications to assess understanding, knowledge retention, and compliance, and that the SN was to assess medication use/compliance at every visit. Additionally, the SN documented at every visit that the patient continued to have a knowledge deficit for medications.</p> <p>The SN failed to ever reassess the caregiver's ability to administer the medication per the plan of care, and failed to develop and implement a medication teaching plan for the patient and caregiver. On 02/02/09 the patient was admitted to the hospital on an emergent basis. The hospital physician's admitting history and physical documented that the patient was admitted with an abnormally low thyroid hormone level, which "had developed over a considerable length of time, likely secondary to the patient not taking any of his medications..... the family did not know what medications the patient takes".</p> <p>When the surveyor interviewed the SN case manager on 05/27/09, she stated that her medication assessment included only asking the grandson if there were any new medications and that she never reviewed the medication list with the caregiver.</p> <p>- coordinate a plan to assess nutritional status. Specifically, the SN failed to obtain an actual weight on the patient, who was ambulating on admission. The SN documented in the 11/05/08 initial nursing assessment that the patient reported his weight to be 180 lbs, however, also</p>	G 143		

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NAME OF PROVIDER OR SUPPLIER

ST JOSEPHS HOSP HEALTH CENTER CHHA

STREET ADDRESS, CITY, STATE, ZIP CODE

7246 JANUS PARK DRIVE  
LIVERPOOL, NY 13088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 143	<p>Continued From page 23</p> <p>documented the patient was confused. The 11/05/08 plan of care included a SN goal of "weight", however, the SN failed to coordinate a weight plan. Specifically, the SN failed to: clarify what the goal was, clarify that the patient did not have a scale as documented in the 12/30/08 recertification assessment, confirm the patient's weight with the physician, and/or assist the patient in obtaining a scale, and coordinate a plan to weigh the patient, including a frequency and reporting parameters to the physician.</p> <p>Although the SN visited the patient 6 times between 11/11/08 and 01/13/09, the SN based the nutritional assessment solely on the caregiver's report of the patient's appetite being adequate to good, and the patient's reported weight of 180 lbs despite her assessment that he was confused.</p> <p>On 02/02/09 the patient was admitted to the hospital on an emergent basis, and had an admission weight of 109.7 pounds. This represented a 70.3 lb. weight loss from the patient's last known weight of 180 lbs. documented by the PCP on 07/20/08.</p> <p>- coordinate a plan to maintain skin integrity. The initial nursing assessment documented that the patient had a decubitus ulcer upon admission to the agency, and the plan of care included skin assessment. The SN failed to reassess the patient's skin after 11/24/08. Specifically, on 12/30/08 the SN visited the patient and documented that the caregiver denied any open areas or skin problems, and there is no evidence the SN observed the patient's skin integrity. On 01/13/09 the SN documented the patient had poor hygiene, however, the SN failed to specify</p>	G 143		

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G 143	<p>Continued From page 24</p> <p>what the patient's skin condition was.</p> <p>On 02/02/09 the physician's hospital admission documented the patient had bed bugs, lice, and a stage 2 sacral decubitus ulcer.</p> <p>- coordinate a plan to ensure the patient's decreasing functional status was reported to the physician, and that a plan was developed to meet his increasing personal care needs. Specifically the 11/05/08 initial nursing assessment documented that the patient was able to participate in bathing himself in the shower or tub, and the patient could transfer himself with minimal assistance or with the use of an assistive device. The 11/24/08 SN follow up assessment documented that although the SN had irrigated the patient's indwelling urinary catheter, palpated his abdomen, and milked the catheter, the patient slept through the SN visit. The 12/30/08 recertification assessment documented that the patient could no longer use the shower or tub and was now being bathed in bed or bedside chair, that the patient was no longer able to transfer himself and was now only able to pivot. The SN failed to report the patient's deteriorating status to the physician, and failed to clarify why the caregiver refused home health aide services, as documented in the 12/30/08 nursing assessment, despite the patient's increasing needs.</p> <p>During the 05/27/09 interview of the SN case manager by the surveyor, the SN stated she was "visiting just for foley catheter care". The SN failed to understand her role as case manager.</p> <p>The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 05/28/09. No additional</p>	G 143			

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NAME OF PROVIDER OR SUPPLIER

ST JOSEPHS HOSP HEALTH CENTER CHHA

STREET ADDRESS, CITY, STATE, ZIP CODE

7246 JANUS PARK DRIVE  
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G 143	Continued From page 25 information was provided.  3. Patient #4 was admitted to the agency on 12/05/08. The 12/05/08 plan of care included SN visits 3 times per week, Physical Therapy (PT), and Social Work evaluations, Home Health Aide services 2-3 times per week for 1 hour. The 12/05/08 initial nursing assessment documented the patient had a stage 3 decubitus ulcer on his sacrum "from being on his back". The SN failed to:  - develop and coordinate an ongoing plan of care which met the patient's needs, and alleviated caregiver stress - coordinated the plan of care with the physician - recognize changes in the patient's condition and report these changes to the physician.  As a result, the caregiver experienced undue stress and anxiety, and the patient was admitted to the hospital on 02/01/09 with a diagnosis of hypovolemic septic shock. The patient subsequently died on 03/03/09. The 02/01/09 admitting physician's physical exam documented that the patient had lost about one-third of his body weight over the previous 1-2 months. The SN failed to:  - coordinate a plan to assess nutritional status. Specifically, although the the SN documented in the 12/05/08 initial nursing assessment that the patient could not be weighed due to his inability to stand, the 12/05/08 plan of care specified that the SN was to visit the patient 1 time per week for 1 week, and 3 times per week for 4 weeks and assess the patient's weight. The SN failed to coordinate a plan to assess the patient's weight per the plan of care, including who would be	G 143	Patient #4 has been discharged from the agency.	

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NAME OF PROVIDER OR SUPPLIER  ST JOSEPHS HOSP HEALTH CENTER CHHA			STREET ADDRESS, CITY, STATE, ZIP CODE 7246 JANUS PARK DRIVE LIVERPOOL, NY 13088		
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G 143	<p>Continued From page 25 information was provided.</p> <p>3. Patient #4 was admitted to the agency on 12/05/08. The 12/05/08 plan of care included SN visits 3 times per week, Physical Therapy (PT), and Social Work evaluations, Home Health Aide services 2-3 times per week for 1 hour. The 12/05/08 initial nursing assessment documented the patient had a stage 3 decubitus ulcer on his sacrum "from being on his back". The SN failed to:</p> <ul style="list-style-type: none"> <li>- develop and coordinate an ongoing plan of care which met the patient's needs, and alleviated caregiver stress</li> <li>- coordinated the plan of care with the physician</li> <li>- recognize changes in the patient's condition and report these changes to the physician.</li> </ul> <p>As a result, the caregiver experienced undue stress and anxiety, and the patient was admitted to the hospital on 02/01/09 with a diagnosis of hypovolemic septic shock. The patient subsequently died on 03/03/09. The 02/01/09 admitting physician's physical exam documented that the patient had lost about one-third of his body weight over the previous 1-2 months. The SN failed to:</p> <ul style="list-style-type: none"> <li>- coordinate a plan to assess nutritional status. Specifically, although the the SN documented in the 12/05/08 initial nursing assessment that the patient could not be weighed due to his inability to stand, the 12/05/08 plan of care specified that the SN was to visit the patient 1 time per week for 1 week, and 3 times per week for 4 weeks and assess the patient's weight. The SN failed to coordinate a plan to assess the patient's weight per the plan of care, including who would be</li> </ul>	G 143	<p>Patient #4 has been discharged from the agency.</p> <p><i>Accepted 8/11/09</i> <i>J DeMantini</i></p>		

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G 143	<p>Continued From page 26</p> <p>responsible, or notify the physician that the patient could not be weighed. Although the SN visited the patient 17 times between 12/05/08 and 01/29/09 the SN failed to ever assess the patient's weight.</p> <p>Additionally, the plan of care included SN assessment of the patient's nutritional intake, and 24 hour intake. The SN, however, failed to ever assess the patient's nutritional intake, and failed to identify that the patient was losing weight. Specifically, on 02/01/09 the patient was admitted to the hospital on an emergent basis. The admitting physician's physical exam included "the patient had complaints of not eating or drinking well over the past one week, and has had a weight loss for the last 1-2 months...the family noted the patient had a weight loss of about one-third his body weight in a 1-2 month period". The physician's hospital discharge summary documented the patient had expired on 03/03/09.</p> <p>On 06/02/09 the surveyor interviewed the SN case manager. The case manager stated that he "would not know how to assess the patient's nutritional intake unless the patient was only taking ensure". When the surveyor questioned why he did not assess the amount of food and fluid the patient was consuming, per the plan of care, he stated, he did not think to ask specifically what the patient was eating and drinking. The surveyor also asked the SN case manager how he was going to perform weight assessments if the patient could not stand on a scale, and he replied "I guess that just got by me."</p> <p>- coordinate a plan with the social worker to address the primary caregivers stress caused by the patient's increasing personal care needs.</p>	G 143			

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NAME OF PROVIDER OR SUPPLIER  ST JOSEPHS HOSP HEALTH CENTER CHHA			STREET ADDRESS, CITY, STATE, ZIP CODE 7246 JANUS PARK DRIVE LIVERPOOL, NY 13088		
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G 143	<p>Continued From page 27</p> <p>Specifically, on 12/11/08 the social worker visited the patient and documented that the wife, who was the primary caregiver, had been able to transfer the patient by herself until recently, and is no longer able to do this. The social worker discussed hiring private aides as an option. The Social Worker and the SN failed to coordinate a plan to assist the wife in obtaining a higher level of care for the patient</p> <p>- coordinate a plan with the PT to address the primary caregiver's stress caused by the patient's increasing personal care needs. Specifically, on 01/12/09 the PT visited the patient and documented reporting to the SN: the wife was "reaching the breaking point", and that the wife stated she could no longer continue to care for the patient, and had inquired about a nursing home transfer. The Physical Therapist also reported that the wife could get the patient into the wheelchair on her own, however, could not get him back to bed. Although the SN was aware of the patient's increasing needs, the SN failed to coordinate a plan with the PT and Home Health Aide (HHA) to address how the patient was to be transferred into and out of bed, arrange for DME such as a hooyer lift to assist in transferring the patient; coordinate a plan to increase the HHA services from 1 hour 3 times per week, to assist and support the wife until arrangements for a higher level of care could be made, or consult with the Supervising Nurse.</p> <p>- Ensure that all services specified on the plan of care are being provided to the patient. Specifically, on 01/27/09 the psychiatric RN assessed the patient and documented: that the wife was unable to care for the patient's incontinence needs, and that she communicated</p>	G 143			

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G 143	<p>Continued From page 28</p> <p>to the SN: the wife was upset because the patient "had not had an aide", the wife was unable to care for the patient alone, the patient had not been out of bed for several days, the patient required a "total clean up", which the aide was providing at the end of the psychiatric nurse's visit. Although a SN visited the patient on 12/29/09, 12/31/08, 01/02/09, 01/06/09, 01/15/09 and 01/22/09, the SN case manager failed to identify that not only had the patient's HHA needs been increasing, but that the patient was not receiving HHA services 3 times per week as required in the plan of care. Specifically, the agency failed to provide HHA services from 12/26/08 - 01/08/09, and 01/22/09 - 01/27/09, and failed to notify the physician.</p> <p>During the 06/02/09 interview with the SN case manager. The case manager stated to the surveyor he did not increase HHA services because he felt the agency was providing all possible services to the patient, and he thought HHA services were limited to 3 times per week per medicare regulations. He then stated that he thought he needed supervisory approval to increase services. The SN could not explain why he had failed to seek such approval from the Supervising Nurse or communicate the patient's increasing needs. Additionally, the SN case manager stated that he did not identify that the patient had not received HHA services as required by the plan of care because he did see it as his role to evaluate if the HHA services are meeting the patient's needs, and only "gets involved" if the patient/caregiver specifically complains about the HHA. The SN failed to understand his case management responsibilities.</p>	G 143		



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G 143	<p>Continued From page 29</p> <p>With the exception of 01/15/09, the SN failed to perform HHA supervisory visits, and during the 01/15/09 supervisory visit, the SN failed to assess if the HHA was following the plan of care.</p> <p>- a coordinated plan for pressure relief of the sacral decubitus ulcer. Specifically, the 12/05/08 initial nursing assessment documented the patient was "quite immobile", must be assisted to turn from side to side, and he prefers to be positioned on his back. Although the SN documented he instructed the patient to stay off the ulcer site as much as possible, evidence is lacking the SN coordinated a plan that included a specific turning frequency with the physician, patient, wife, Home Health Aide (HHA), or for pressure relieving DME. Specifically, although the 12/03/08 physician referral included an air overlay for the hospital bed, and gel overlay for chair, evidence is lacking the patient received the air mattress until 12/29/08, or ever received the gel overlay for the wheelchair.</p> <p>- a coordinated plan for hallucinations. Specifically, on 12/16/08 the PT documented that the patient was having hallucinations, however, evidence is lacking this was reported to the physician or discussed with the SN. Evidence is lacking a plan was coordinated and implemented for the hallucinations until the psychiatric RN visited the patient on 01/27/09.</p> <p>The patient record was reviewed with the DPS, ADPS, supervising RN on 06/03/09. No additional information was provided.</p> <p>4. Patient #20 was admitted to the agency on 11/30/08. The plan of care included SN visits 2 times per week and PT 3 times per week. On</p>	G 143	<p>Patient #20 has been discharged from the agency.</p>		

*accepted 8/11/09*  
*St Demetrio*

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NAME OF PROVIDER OR SUPPLIER

ST JOSEPHS HOSP HEALTH CENTER CHHA

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G 143	Continued From page 30 12/16/08, the SN visited the patient, and the patient's daughter reported that the patient had fallen the prior day, and consistently did not use her walker. The SN discharged the patient from nursing services, and failed to report to the physician or the PT that the patient had fallen, and coordinate a plan to prevent future falls.  On 12/21/08 the SN documented in the Patient Activity Log that the patient had been hospitalized following another fall which resulted in a fractured hip.	G 143		
	The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 06/08/09. No additional information was provided.  HV 5. Patient #10 was admitted to the agency on 04/23/09. The SN failed to coordinate the patient's care, which resulted in undue stress and anxiety for the patient and family, as follows:  - On 04/23/09 the SN documented in the initial assessment that the patient had a foot wound which was being treated by hyperbaric therapy at the wound care center. The SN failed to coordinate a wound care plan with the wound care center, and instead instructed the patient's wife to obtain a prescription from the physician for wound care instructions.  - On 04/25/09 the SN visited the patient and documented she observed the wife performing the dressing change, however, the SN never obtained wound care orders from a physician, and it is unclear how the SN knew if the correct dressing was being applied.		Patient #10 has been discharged from the agency.  <i>Accepted 8/11/09</i> <i>At Remerhu</i>	

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G 143	<p>Continued From page 31</p> <p>- On 04/26/09 the SN visited the patient and documented that she was not assessing the wound because physician orders had not yet been obtained for wound care. The SN failed to understand it was her responsibility to coordinate a wound care plan with the physician/wound care center.</p> <p>- On 05/28/09 an observational home visit was conducted by the surveyor with the SN. During the visit the SN changed the dressing on the patient's foot, which included packing the dressing with betadine gauze. The SN, however, failed to obtain physician orders for wound care prior to performing the dressing change.</p> <p>- On 05/14/09 the SN documented the patient had new toe wounds # 2-5. Although the patient was attending the wound care clinic for the foot wound, the SN failed to coordinate a wound care plan with the clinic for the toe wounds. The SN instead documented that the patient was told by a podiatrist to keep an eye on the wounds. The SN failed to coordinate a plan with the wound care clinic, podiatrist, and patient for the care of the toe wounds.</p> <p>- The plan of care included IV antibiotic administration via a peripherally inserted central catheter (PICC). During the observational home visit the patient's wife stated to the surveyor that during the patient's first week at home, she was changing the patient's IV antibiotic bag for the first time independently. She had a question during the procedure and attempted to phone the agency, however, the agency failed to return her call, and she stated tot he surveyor she just "did the best she could". She later found out that the</p>	G 143			

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G 143	<p>Continued From page 32</p> <p>SN had returned the call to the daughter's voice mail, where the patient had previously resided. Although the SN had visited the patient in his own home on 04/27/09, the SN failed to update the patient record to indicate this. This resulted in the SN failing to make contact with the patient's wife, who felt forced to hang a new IV bag for the first time without the needed assistance from the agency.</p> <p>- The SN case manager failed to coordinate a complete and accurate PICC line care plan with all of the SNs, the physician, and the family, which caused undue stress and anxiety for the patient and his family. Specifically, during the observational home visit the wife told the surveyor that following the above incident the SN visited and told the wife that she had flushed the PICC line incorrectly. The patient and wife stated that they found the instructions very confusing because during the first week, several different SNs were visiting, and each nurse had given the patient /wife different instructions on flushing the PICC line.</p> <p>The 04/23/09 PICC line plan of care was confusing and incomplete. Specifically the plan included:</p> <p>zosyn 3.375 gm IV every 6 hours, however, failed to specify which lumen the zosyn should be infused through.</p> <p>heparin lock flush 100units/ml 3cc daily; saline flush syringe 3cc IV push daily, however, failed to specify which lumen should be used</p> <p>instruct patient to flush red port daily with 3cc heparin. Instruct patient to use SASH method for infusion, flush with 3cc normal saline when starting infusion and with tubing change. Flush</p>	G 143			

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NAME OF PROVIDER OR SUPPLIER  ST JOSEPHS HOSP HEALTH CENTER CHHA			STREET ADDRESS, CITY, STATE, ZIP CODE 7246 JANUS PARK DRIVE LIVERPOOL, NY 13088		
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G 143	<p>Continued From page 33</p> <p>with 3cc normal saline then 3cc heparin if staying disconnected.</p> <p>The initial nursing assessment documented that the patient had a double lumen PICC line, however, there is no plan for the maintenance of the second lumen.</p> <p>Although the SNs visited daily, the SNs PICC line flushing regime was inconsistent, and either incomplete, and/or failed to follow the plan of care. Specifically the SNs documented:</p> <p>On 04/23/09 - PICC line was flushed, but no specifics were documented by the SN for solution type or amount, or port used.</p> <p>On 04/24/09 - 3 cc heparin to red port, there is no indication if this was heparin flush, and no indication of saline flush to the second port.</p> <p>On 04/25/09 - 3cc heparin to unused line - SASH (saline-administer drug-saline-heparin) to antibiotic line. There is no indication if the SN used heparin flush per the plan of care, or what the SN actually administered during the visit as part of the SASH protocol, or which lumens were used.</p> <p>On 04/26/09 - heparin to red port. There is no indication if this was heparin flush, and no indication of saline flush to the second port per the plan of care.</p> <p>On 04/27/09 - saline before and after blood draw, heparin following blood draw to red port, the SN failed to specify the amount of flushed used. The plan specified for blood draws: flush red lumen with 10cc normal saline, then waste 10cc blood, draw labs, then flush with 10cc normal saline, followed by 3cc "heparin".</p> <p>On 04/28/09 - 3cc heparin 100units/ml to red port- SASH to blue port. The SN failed to specify what was included in the SASH, including what</p>	G 143			

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G 143	Continued From page 34 medication was administered as there is no medication for the second port. On 04/29/09 - 3cc normal saline to blue lumen, 3 ml heparin to red lumen.  The patient record was reviewed with the DPS and ADPS on 05/28/09. No additional information was provided.  HV 6. Patient # 14 was admitted to the agency on 04/06/09. The 04/06/09 plan of care included flush PICC line with 10cc normal saline daily followed by 3cc heparin 100 units/ml. The SN failed to coordinate a plan of care for the PICC line as follows:  - On 05/18/09 the SN visited the patient and documented that the patient's PICC line was falling out. The SN reported this to the patient's daughter, who "was to call the physician for further directions". Although the SN called the physician, and obtained an order to draw labs peripherally, there is no evidence the SN reported the PICC line migration to the physician. The SN relied on the daughter, and failed to consult plan of care with the physician until 2 days later on 5/20/08, at which time the SN removed the PICC line.  - On 06/02/09 the surveyor made an observational home visit with the SN. During the visit the privately hired caregiver told the surveyor that there were several privately hired caregivers who flushed the patient's PICC line once every evening, and that they had taught each other how to perform this function. Review of the patient record revealed that the SN had taught 2 of the privately hired caregivers how to	G 143	Patient #14 has been discharged from the agency.		
			Accepted 8/11/09 J. Demarsh		

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G 143	Continued From page 35 flush the PICC line and both were independent. However there were at least 2 additional caregivers who were providing care to the patient, and evidence is lacking the SN ever taught them to flush the PICC line prior to them assuming that responsibility.  On 06/04/09 the surveyor reviewed the record with the DPS and ADPS. On 06/10/09 the ADPS stated that the SN case manager had not been aware that there were additional caregivers flushing the PICC line until the surveyors visit, and that there were 3 caregivers currently flushing the patient's PICC line who had not been taught by the SN, and who in fact had taught each other how to flush the line.  7. Patient #16 was admitted to the agency on 5/29/09. The patient record contained a 10/09/08 progress note from the urologist which documented that the patient's medical condition had been declining due to nutritional issues. The plan of care included: Jevity Plus via gastric tube three times per day; SN visits 1-3 times per week to assess GI status nutritional status; and hydration status; a Registered Dietician (RD) evaluation. The SN failed to coordinate a nutritional plan for the patient as follows:  - On 05/29/09 the SN documented that the patient reported a weight of 160 lbs, and that the patient did not have a scale. The SN failed to coordinate a plan to weigh the patient. Specifically, the SN failed to confirm the patient's weight with the physician, and/or report to the physician a weight could not be obtained and/or assist the patient in obtaining a scale.  - On 6/2/09, the Registered Dietician (RD)	G 143			
			Patient #16: <ul style="list-style-type: none"> <li>Plan of care revised to include plan for weekly weight monitoring. Patient now has scale in home.</li> <li>Admission nurse (05/19/09) no longer works for CHHA; unable to remediate.</li> </ul> <i>Accepted 8/11/09</i> <i>H. Domastus</i>		

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G 143	Continued From page 36 assessed the patient and recommended monitoring the patient's weight. The RD failed to coordinate a plan with the SN and physician, which included: how the patient would be weighed, who would be responsible for weighing the patient, the frequency of weights, and reporting parameters to the physician.  Despite the patient's at risk nutritional status, and the plan of care requirement for weight assessment, the SN failed to ever obtain the patient's weight.  The patient record was reviewed with the DPS and ADPS on 06/11/09. No additional information was provided.	G 143	Patient #16 continued: <ul style="list-style-type: none"> <li>RD counseled re: responsibility to coordinate plan for patients with SN and MD. In particular, plan for routine weights and parameters to notify MD.</li> <li>RN counseled re: responsibility to identify patients at nutritional risk and to follow the plan of care.</li> </ul>		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES  The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.  This STANDARD is not met as evidenced by: Based on a review of 27 clinical records, review of agency policies, and interviews with the Director of Patient Services (DPS) and Assistant Director of Patient Services (ADPS) between 05/26/09 and 06/11/09, there is no evidence in 17 records, that case conferences are being conducted on a regular basis to ensure effective interchange, reporting, and coordination of patient care occurs. Patients # 2 - 5, 7, 8, 10 - 12, 14 - 18, 20, 24, 27  Lack of adequate case conferencing has resulted	G 144	<p><i>Accepted</i> <i>8/11/09</i> <i>J. DeMarino</i></p>		



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G 144	Continued From page 37 in negative outcomes for 5 patients, (patients # 3, 4, 10, 20, 27), and has the potential for agency wide unmet patient needs and negative patient outcomes. Patient # 20 was identified on the OBQI Adverse Events Outcome Report for 2/2008 - 1/2009 for emergent hospitalization resulting from a fall.  On 06/09/09 the DPS stated to the surveyor that interdisciplinary case conferences take place only as needed, and are not scheduled at regular intervals.  The agency's 5/2008 policy titled "Coordination of Care", specifies triggers for case conferencing, which include, but are not limited to: multidisciplinary services, patients requiring daily visits, discipline discharge, recertification. The policy, however, states only that the case conferences may be appropriate, and fails to indicate that case conferences are required. Additionally, the policy fails to specify the frequency with which case conferences must take place.  Additionally, the DPS stated that the Supervising Nurses are expected to conduct patient case conferences with the SN case managers every 1 - 2 weeks. There is no documentation in any patient record of SN Supervisory case conferences every 1-2 weeks. The DPS provided the surveyor with separate documentation. The documentation failed to include at least one of the following: the date of the case conferences, conferencing of every patient in the SNs case load, evidence that the Supervising Nurses are identifying problems with care coordination, as identified in this report. See G 143	G 144	<b>G144 Coordination of patient services</b>  <b>See G143 for Coordination of Care detail</b>  Establishment of formal Case Conference Team to meet weekly with staff to conference designated patients. Patients to be designated for review by any member of the interdisciplinary team. Supervising Nurses and all disciplines involved to attend the conferences, DPS or ADPS and psychiatric CNS to facilitate the Case Conferences.  Conferences. Case conferences are documented in the patients medical record. Completion date: August 5, 2009 Responsible person: ADPS PI Coordinator  DPS and Supervising Nurses to identify high risk patients. High risk patients are identified as patients with safety concerns, caregiver issues, complex care or social needs, and/or non-compliance. DPS and Supervising Nurses will conference on all cases at least once weekly and PRN to assure care coordination, adequate planning, appropriate interventions, and ongoing communications to physician(s) and internal and external care providers, until problem/concern resolution is assured. Conferencing will be documented.  Completion date: August 10, 2009 Responsible person: DPS Supervising Nurses		
G 156	484.18 ACCEPTANCE OF PATIENTS, POC,	KV156			

*Accepted 8/11/09  
A DeMandue*

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NAME OF PROVIDER OR SUPPLIER  ST JOSEPHS HOSP HEALTH CENTER CHHA	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 JANUS PARK DRIVE LIVERPOOL, NY 13088
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G 156	Continued From page 38 MED SUPER  This CONDITION is not met as evidenced by: o Failure to consistently follow a written plan of care. G158  o Failure to implement a system which ensures: that plans of care are comprehensive and address each patient's needs. This survey identifies the agency's failure to develop individualized plans of care which include specific interventions necessary to adequately assess and treat patient conditions and address significant patient symptoms. G159  o Failure to consistently alert the physician when changes in the patient's condition suggest a need to modify the plan of care. G164  The cumulative effect of these systemic problems in the development, implementation, and modification of the plan of care resulted in a negative outcomes for 7 patients (Patients # 1, 3, 4, 20, 22, 23, 27), including 3 patient deaths (patients # 3, 4, 27), and the potential for negative outcomes for the agency's entire patient population and the potential for unmet patient needs.		Coordination of Care policy to be updated to include the following specific identifiers for Case Conferencing:  <ul style="list-style-type: none"> <li>Any safety concerns</li> <li>Non-compliance</li> <li>Psycho-social issues impacting provision of care</li> <li>Significant change in condition</li> <li>Unexpected/unplanned change in caregiver</li> <li>Caregiver issues</li> <li>Complex care/needs</li> </ul> Education to new policy to be provided to all professional staff.  Completion date: August 10, 2009 Responsible person: DPS ADPS	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.	G 156	G156 Acceptance of Patients, POC, med supervision  See G140 for Supervision of Plan of Care See G143 Coordination of Care, physician See G156 for development of Plan of Care See G158 for development of POC See G229 for HHA Supervision and coordination  See G250 for QA detail to monitor  The Agency has realigned clinical Teams to include the assignment of 100% SOC/RECERT OASIS-POC review RN who works in tandem with the Supervising Nurse in overseeing the adequacy of nursing assessments and the development of a Plan of Care that meets the identified assessed needs of each individual patient.	

Accepted 8/14/09  
H. Demarino

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G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.		<ul style="list-style-type: none"> <li>Development of a complete Plan of Care that addresses all the assessed needs of the patient</li> <li>All care and interventions to be provided included the Plan of Care</li> </ul>		

*Accepted 8/11/09*  
*St. Rose*

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NAME OF PROVIDER OR SUPPLIER

ST JOSEPHS HOSP HEALTH CENTER CHHA

STREET ADDRESS, CITY, STATE, ZIP CODE

7246 JANUS PARK DRIVE

LIVERPOOL, NY 13088

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G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.		<p>Complete date: July 24, 2009 Responsible person: DPS/ADPS</p> <p>Supervising Nurses to perform 1:1 weekly case review with each Case Manager for oversight of Case Management, including completeness of assessments and reassessments, following the Plan of Care, coordination of care with internal and external providers, communication of patient issues amongst caregivers, appropriateness and quality of care being provided, management of patient safety issues, emergency planning, communication with physician as approp. for changes in condition, problem and assessment follow-up, completeness and timeliness of documentation, and compliance with agency policy and stds. specific to each patient.</p> <p>Case review will be documented in the patient's medical record and will include a plan to address ongoing problems. Case reviews are to include HHA visit compliance and HHA supervision compliance.</p>	

Completion date: 07/14/09

Responsible person: Supervising Nurses

*Accepted 8/11/09*  
*H. [Signature]*

39B

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

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G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.				

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NAME OF PROVIDER OR SUPPLIER  ST JOSEPHS HOSP HEALTH CENTER CHHA			STREET ADDRESS, CITY, STATE, ZIP CODE 7246 JANUS PARK DRIVE LIVERPOOL, NY 13088		
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G 158	<p>Continued From page 39</p> <p>This STANDARD is not met as evidenced by: Based on a review of 27 clinical records and interviews with the Director of Patient Services (DPS) and Assistant Director of Patient Services (ADPS), evidence is lacking in 13 records that the plan of care developed by the physician is followed by all disciplines providing care. Patients # 1 - 5, 8, 10, 11, 12, 16, 17, 22, 24</p> <p>Failure to ensure that the plan of care resulted in a negative outcome for patient #4, and has the potential for agency wide negative outcomes and unmet patient needs.</p> <p>1. Patient #4 was admitted to the agency on 12/05/08. The 12/05/08 plan of care specified that the SN was to visit the patient 1 time per week for 1 week, and 3 times per week for 4 weeks and assess the patient's weight, and Home Health Aide (HHA) services 3 times per week. Although the SN visited the patient 17 times between 12/05/08 and 01/29/09 the SN failed to ever assess the patient's weight per the plan of care, or that the patient was not receiving HHA services per the plan of care, which resulted in the SN failing to identify that the patient had experienced a significant unreported weight loss, and that the patient's personal care needs were not being met.</p> <p>Specifically, the patient was admitted to the hospital on 02/01/09 with a diagnosis of hypovolemic septic shock. The patient subsequently died on 03/03/09. The 02/01/09 admitting physician's physical exam documented the following "the patient had complaints of not eating or drinking well over the past one week, and has had a weight loss for the last 1-2 months...the family noted the patient had a weight</p>	G 158	<p>G158 Acceptance of patients, POC, med supervision</p> <p>See G168 for education for following the Plan of Care</p> <p>See G140 for enhanced supervision</p> <p>See G250 for QA detail to monitor</p> <p>Patient #4 has been discharged from the agency.</p> <p><i>Accepted 8/11/09 H DeMantone</i></p>		

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G 158	<p>Continued From page 40</p> <p>loss of about one-third his body weight in a 1-2 month period". The physician's hospital discharge summary documented the patient had expired on 03/03/09.</p> <p>Additionally, a SN visited the patient on 12/29/08, 12/31/08, 01/02/09, 01/06/09, 01/15/09 and 01/22/09, the SN case manager failed to identify that the patient was not receiving HHA services 3 times per week as required in the plan of care. Specifically, the agency failed to provide HHA services from 12/26/08 - 01/08/09, and 01/22/09 - 01/27/09, and failed to notify the physician. As a result this caused undue stress and anxiety for the primary caregiver, and the patient's personal care needs not being met.</p> <p>Specifically, on 01/12/09 the PT visited the patient and documented reporting to the SN: the wife was "reaching the breaking point", and that the wife stated she could no longer continue to care for the patient, and had inquired about a nursing home transfer. The Physical Therapist also reported that the wife could get the patient into the wheelchair on her own, however, could not get him back to bed.</p> <p>Additionally, on 01/27/09 the psychiatric RN assessed the patient and documented: that the wife was unable to care for the patient's incontinence needs, and that she communicated to the SN: the wife was upset because the patient "had not had an aide", the wife was unable to care for the patient alone, the patient had not been out of bed for several days, the patient required a "total clean up", which the aide was providing at the end of the psychiatric nurse's visit. Although a SN visited the patient on 12/29/09, 12/31/08, 01/02/09, 01/06/09, 01/15/09</p>	G 158			

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G 158	Continued From page 41 and 01/22/09, the SN case manager failed to identify that not only had the patient's HHA needs been increasing, but that the patient was not receiving HHA services 3 times per week as required in the plan of care. Specifically, the agency failed to provide HHA services from 12/26/08 - 01/08/09, and 01/22/09 - 01/27/09, and failed to notify the physician.  The patient record was reviewed with the DPS, ADPS, supervising RN on 06/03/09. No additional information was provided.	G 158			
	2. Patient # 5 was admitted to the agency on 03/05/09. The 03/05/09 initial nursing assessment documented that the patient required a higher level of care. The Skilled Nurse (SN) assessed that the patient's safety and personal care needs could be met by the provision of daily Home Health Aide (HHA) services, which was critical to the patient's safety plan, and which the family, patient, and physician agreed to. This was included in the 03/05/09 plan of care, however, the plan of care was not followed as follows:  - There is no evidence in the record that the agency provided HHA services on 3/09/09, 3/11/09, 3/12/09, 3/15/09, 3/16/09, 3/18/09, 3/20/09, 3/25/09, or that the physician was notified. - On 04/02/09 the SN documented the patient no longer wanted daily HHA services, and obtained physician orders to decrease the HHA services to 2 times per week. There is no evidence any HHA services were provided to the patient after 3/26/09, or that the physician was notified. - The 03/05/09 plan of care specified SN visits daily for wound care. There is no evidence the SN		Patient #5: <ul style="list-style-type: none"><li>05/01/09: POC reviewed with MD, SN only ordered service at that time; no HHA service at this time.</li><li>RN counseled regarding communication with MD r/t changes in plan of care.</li><li>RN counseled regarding responsibility to ensure wound assessment including: measurement by RN every 7 days.</li></ul> <i>accepted 8/11/09</i> <i>W DeMott</i>		



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G 158	Continued From page 42 visited the patient on 03/18/09, 3/25/09, 04/11/09, 4/20/09, 4/29/09, 05/04/09, 4/10/09, 4/12/09, 4/16/09.  - Although the RN measured wounds 1-8 on the 03/05/09 initial assessment, and visited the patient at least weekly from 03/05/09 to 04/15/09, the RN failed to measure the wounds weekly as specified in the agency's 02/2009 Standard of Care policy for wounds. Specifically, the RN failed to ever measure wound #4 after the initial assessment, or indicate it was healed, and failed to measure wound #1 from 03/27/09 to 04/24/09.	G 158			
	- The RN failed to conduct a home visit to assess the patient from 04/15/09 to 04/24/09 to assess the patient, including any wound and skin assessments. Only an LPN visited the patient during this time period.  The patient record was reviewed with the DPS and ADPS on 06/03/09, no additional information was provided.  HV 3. Patient # 17 was admitted to the agency on 05/21/09. The SN failed to follow the 05/21/09 plan of care as follows:  - The plan included SN assessments 1 - 2 times per week for 4 weeks, however, there were no RN visits following the 05/21/09 initial nursing assessment. Specifically, all of the follow up visits from 05/21/09 to 06/02/09 were made by an LPN, and LPNs are not qualified to perform patient assessments per the NYS Education Law article 139 section 6902.. - The plan included assessment by the		Patient #17 has been discharged from the agency.  <i>Accepted 8/11/09</i> <i>H DeMarino</i>		

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G 158	<p>Continued From page 43</p> <p>Psychiatric Nurse within 1 week, however, the Psychiatric Nurse failed to ever visit the patient, and failed to notify the physician of a delay.</p> <ul style="list-style-type: none"> <li>- The plan of care included an Occupational Therapist (OT) assessment within 1 week, however, the OT failed to visit the patient until 13 days later on 06/03/09.</li> <li>- The plan of care documented that the SN was to assess the patient's medication compliance, however, there is no evidence the SN ever assessed the patient's medication compliance.</li> </ul> <p>On 06/03/09 the surveyor made an observational home visit with the Occupational Therapist. During the visit the surveyor identified the patient was not following the plan of care for medications, and the patient told the surveyor he was confused about which medications he should be taking. Specifically:</p> <p>The plan included buspirone 15 mg 1 time per day, however, the patient stated he does not take this medication</p> <p>The patient stated he takes loperamide 2 mg as needed for diarrhea, which is not on the plan of care.</p> <p>The patient was taking paroxetine (paxil) 10mg 1 time per day, however, this is not on the plan of care. The patient stated he attempted to fill a prescription for paxil, however, the pharmacist would not fill it "because of the other medications" he was taking. The patient was unaware that paroxetine and paxil were the same medication.</p> <p>The patient stated he filled a prescription for citalopram, however he is not taking the medication because he lost it. This medication is not on the plan of care.</p> <p>Additionally, on 06/02/09 the social worker visited the patient and documented the patient was</p>	G 158			

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KVRW11

Facility ID: 5987

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accepted 8/11/05  
J. R. Martin

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G 158	Continued From page 45 The SN failed to follow the plan of care as follows:  - The agency's 02/2009 Standard of Care for Wounds specifies the SN is to measure wounds weekly, and the SN failed to measure the wounds weekly. The SN measured the wounds only on 1/25/09, 2/8/09 and 2/21/09. - The plan of care included weight assessment, however, the SN failed to ever weigh the patient following the 01/23/09 initial nursing assessment, failed to document why the patient was not weighed or notify the physician. - The plan of care included assessment of skin integrity. On 02/16/09 the SN documented the wound on the patient's left heel was healed, and that the patient had dried cracked skin in the area. The SN failed to ever re-assess the skin integrity of the left heel. - The 01/23/09 plan of care included edema assessment. The agency's 12/2008 Standard of Care for Edema specifies weekly leg measurements for lower extremity edema, and palpation of pedal pulses. Although the SN documented at every visit from 01/26/09 to 02/21/09 the patient's legs were "grossly swollen", the SN failed to measure the patient's lower extremities during this time period, or palpate for pedal pulses.  The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 06/04/09. No additional information was provided.	G 158			
G 159	484.18(a) PLAN OF CARE  The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits,	G 159			

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G 159	<p>Continued From page 46</p> <p>prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 27 clinical records, and interviews with the Director of Patient Services (DPS) and Assistant Director of Patient Services (ADPS), and agency staff, there is no evidence in 22 records the plan of care developed is of sufficient scope to meet the patient's needs. Patient #1 was identified on the OBQI Adverse Events Outcome Report for 2/2008 - 1/2009 for emergent hospitalization resulting from wound infection. Patients # 1 - 8, 10, 12 - 17, 21 - 27</p> <p>Lack of a complete and accurate plan of care resulted in a negative outcome for patients # 1, 3, 4, 22, 23, 27, including 2 deaths, patients # 3, 27, and has the potential for unmet patient needs and possible negative patient outcomes agency wide.</p> <p>Examples are as follows:</p> <p>1. Patient # 27 was admitted to the agency on 09/09/08. On 03/06/09 the SN conducted a comprehensive recertification nursing assessment. The 03/08/09 updated plan of care included a primary diagnosis of open wound, and included SN visits 2 times per week for 8 weeks for wound care, foley catheter maintenance, and assessment.</p> <p>On 04/29/09 the patient was admitted to the hospital on an emergent basis, after being pinned</p>	G 15	<p><b>G159 Plan of Care</b></p> <p>See G156 for education regarding developing the Plan of Care</p> <p>See G240 for enhanced Supervision in development of the Plan of Care</p> <p>See G250 for enhanced QA activity to monitor complete and appropriate Plans of Care</p> <p>ADPS reassigned in June to clinician follow-up related to survey deficiencies and Plan of Correction; current month Adverse Event auditing to identify opportunities for improvement in care provided to those patients remaining open to the agency. Additionally, a process was established for ADPS to review all records of patients transferred to acute care on a weekly basis to identify opportunities for improvement upon Resumption of Care. Opportunities for improvement are provided in writing to Supervising Nurses for clinician follow-up and care coordination upon Resumption of Care.</p> <p>Completion date: June 29, 2009</p> <p>Responsible person: DPS</p> <p>100% review of Resumptions of Care OASIS and ordered care done for thoroughness of assessment and appropriateness of ongoing care plan and orders. Follow-up is done with clinician and Supervising Nurse as needed.</p> <p>Completion date: August 3, 2009 Responsible person: OASIS Reviewer</p> <p>Patient #27 has been discharged from the agency.</p>		

*accepted 8/11/09  
H. Romaine*

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G 159	<p>Continued From page 47</p> <p>to the floor at home for 2 days, despite having called the agency for help on 04/27/09, and subsequently died on 06/10/09. The plan of care failed to include:</p> <ul style="list-style-type: none"> <li>- A plan for Home Health Aide (HHA) services to meet the patient's safety and personal care needs. Specifically, on 10/06/08 the social worker documented that the patient was applying for medicaid, and had a privately hired caregiver 3 hours per day, 5 days per week. On 03/06/09 the Skilled Nurse (SN) case manager documented in the comprehensive assessment the patient: was confused, had impaired decision making, required assistance with bathing, and dressing, had a privately hired aide. The plan of care failed to include HHA services provided by the agency. Consequently the patient was forced to assume the financial responsibility of the provision of personal care assistance.</li> </ul> <p>On 07/09/09 2 surveyors interviewed the SN case manager. The case manager stated to the surveyors: the patient was happy with her private aide, she did not know why the agency was not providing a HHA for the patient, the decision to not provide an aide had been made prior to her taking over as the case manager (on 03/02/09).</p> <p>During the 07/13/09 interview with the patient's daughter, the daughter told the surveyor that the agency had never offered the services of a HHA, and that if they had been offered, she and her mother would have "most definitely" accepted them.</p> <ul style="list-style-type: none"> <li>- The patient required a wheelchair for mobility, per a patient's 04/27/09 phone call to the agency, when she reported that she could not transfer</li> </ul>	G 159			

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G 159	<p>Continued From page 48 from the toilet to the wheelchair.</p> <p>- A plan for the patient to summon help in the event of an emergency. On 10/06/08 the social worker visited the patient and documented that the patient had a Personal Emergency Response System (PERS). On 03/06/09 the SN case manager documented that the patient was able to walk only with the supervision or assistance of another person at all times, could transfer herself, had a fear of falling. The SN case manager failed to develop a plan for how the patient was able to mobilize when the private caregiver was not present, and the plan of care failed to indicate what mechanism the patient was to use to summon help.</p> <p>On 07/09/09.2 surveyors interviewed the social worker and the SN case manager. The social worker stated she could not remember how she identified that the patient had a PERS, or if she had discussed it with the SN. The SN case manager stated she did not know if the patient had a PERS, but thought that the patient "would have probably activated it, if she had one, the night of her fall".</p> <p>On 07/13/09 the surveyor interviewed the patient's daughter. The daughter stated that the patient did not have a PERS, and that the patient wore her cordless phone around her neck.</p> <p>The patient record was reviewed with the Administrator, DPS, ADPS, Supervising Nurse on 07/16/09. Following the conclusion of the record review, the surveyor requested a policy of the agency's procedure when a patient is not found at home, and fails to answer the phone for a follow up visit. The DPS responded via e-mail, indicating.</p>	G 159			

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G 159	<p>Continued From page 49</p> <p>the agency does not have a written policy with specific steps that should be taken, including contacting emergency contacts, and reporting to the physician.</p> <p>2. Patient #4 was admitted to the agency on 12/05/08. The 12/05/08 initial nursing assessment documented the patient had a stage 3 decubitus ulcer on his sacrum "from being on his back". The plan of care included Home Health Aide services 2-3 times per week for 1 hour. The 12/05/08 plan of care was incomplete which resulted in the patient requiring emergency hospitalization. Specifically, the plan of care failed to include:</p> <p>- an appropriate plan to weigh the patient. Specifically, the plan of care documented the Skilled Nurse (SN) should weigh the patient at every visit, however, the 12/05/08 initial nursing assessment documented that the patient could not stand up to be weighed. The SN failed to assess the patient's weight between 12/05/08 and 02/01/09, and failed to notify the physician that the patient could not be weighed. On 02/01/09 the patient was admitted to the hospital on an emergent basis. The hospital admitting physician's physical exam included "the patient had complaints of not eating or drinking well over the past one week, and has had a weight loss for the last 1-2 months...the family noted the patient had a weight loss of about one-third his body weight in a 1-2 month period." The physician's discharge summary documented the patient had expired on 03/03/09.</p> <p>On 06/02/09 the surveyor interviewed the SN case manager. The surveyor asked the SN case manager how he had planned to perform weight</p>	G 159	<p>Patient #4 has been discharged from the agency.</p> <p><i>accepted 8/11/09</i> <i>Li De Nardis</i></p>		



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G 159	<p>Continued From page 50</p> <p>assessments if the patient could not stand on a scale, and he replied "I guess that just got by me."</p> <p>- a complete skin care plan. Specifically, the 12/05/08 initial nursing assessment documented that the patient had a red, painful heel, however, the plan of care failed to include a plan to reassess the heel, or a pressure relief plan for the heel.</p> <p>Additionally, the 12/03/08 physician referral documented that the patient was to wear heel protectors, however, the plan of care failed to include this.</p> <p>- a complete medication plan. Specifically, the plan failed to include B 12, tylenol, or Vitamin C per the 12/10/08 SN visit.</p> <p>- The HHA instructions failed to include: any instructions to report changes in skin integrity to the SN, a frequency for bathing, shampooing, shaving, or grooming the patient, a specific plan for how the patient was to be transferred or repositioned, that the patient was to wear heel protectors. On 02/02/09 the patient was admitted to the hospital on an emergent basis. The physician's hospital admission note documented the patient had bed bugs, lice, and a stage 2 sacral decubitus ulcer.</p> <p>The patient record was reviewed with the DPS, ADPS, supervising RN on 06/03/09. No additional information was provided.</p> <p>3. Patient #23 was admitted to the agency on 04/03/09. The SN documented on the initial</p>	G 159			

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G 159	Continued From page 51 assessment that the patient had a new colostomy; was alert but confused at times, and resided in an adult home. The 04/03/09 plan of care included SN visits 3 times per week for abdominal dressing changes. The plan of care was incomplete and resulted in the patient losing 16 lbs that was not reported to the physician. Specifically, the plan failed to include:  - a plan to assess gastrointestinal/nutritional status, including obtaining weights with a frequency specified by the MD and parameters for reporting weight changes. This resulted in the SN not weighing the patient for 1 month, despite the new colostomy. On 04/03/09 the SN documented that the patient weighed 194 lbs. Although the SN visited the patient daily from 04/03/09 - 05/07/09, the SN failed to weigh the patient until one month later on 05/07/09. On 05/07/09 the SN documented the patient weighed 178 lbs, which represented a rapid unintended weight loss of 16 lbs. The SN failed to report this to the physician.  - a complete plan of care for the colostomy. Specifically, the plan failed to include: the type of ostomy appliance, the care of the skin surrounding the ostomy, who was responsible for providing the ostomy care, and a plan for the SN to re-assess the ostomy site.  - a plan for edema assessment. Specifically, although the SN documented in the 04/03/09 initial nursing assessment that the patient had bilateral lower extremity edema, and the plan of care included a diagnosis of edema, the plan failed to include a plan to assess edema, including leg measurements, measurement frequency, and parameters for reporting changes	G 159	Patient #23: <ul style="list-style-type: none"><li>Admission RN counseled regarding responsibility to develop a complete POC that includes assessment and plan for reporting changes to MD for the following: weights, GI/nutritional status, colostomy, edema.</li><li>05/07/09 failure to report weight loss to MD. RN no longer works at CHHA; unable to remediate.</li><li>Ostomy was reversed on 06/19/09; no orders needed at this time.</li><li>Plan now includes routine measuring of edema and weight.</li></ul> <i>Accepted 8/11/09 J. DeMartino</i>		

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KVRW11

Facility ID: 5987

If continuation sheet Page 53 of 92

accepted 8/11/09  
H. R. Martin

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G 159	Continued From page 53 cancer, a new colostomy and weight loss. The 05/15/09 plan of care failed to include a complete nutritional plan. Specifically, the plan failed to include:  - a plan to weigh the patient, including the frequency with which the patient was to be weighed and reporting parameters for weight change to the physician. On 5/15/09, the SN documented the patient's weight at 168 pounds, and on 5/29/09 the SN documented his weight at 153 lbs. The SN failed to report this 15 lb. weight loss in a 14 day period to the physician.	G 159		
	- a plan for an evaluation by the nutritionist.  The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 06/08/09. No additional information was provided.  6. Patient #1 was admitted to the agency on 01/18/09. The 01/18/09 plan of care was incomplete, and failed to include a wound care plan for the scrotal wound. Specifically, although the SNs changed a scrotal dressing daily from 01/18/09 - 01/22/09, the plan of care failed to document the patient had a scrotal wound, or specify wound care. The wound became infected, and the patient required emergency hospitalization for IV antibiotics.  On 01/22/09 the SN assessed that the scrotal wound was draining. Although the SNs visited the patient on 01/23/09 and 01/24/09, the SN failed to document if wound care was performed.  On 01/25/09 the patient was admitted to the hospital on an emergent basis. The hospital		Patient #1 has been discharged from the agency.  <i>Accepted 8/11/09</i> <i>A. Demetree</i>	

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G 159	Continued From page 54 record documented that the patient required an immediate incision and drainage of the right scrotal sac, and IV antibiotics.	G 159			
G 160	The patient record was reviewed with the DPS and ADPS on 05/28/09. No additional information was provided. 484.18(a) PLAN OF CARE  If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan.  This STANDARD is not met as evidenced by: Based on a review of 27 patient records, there is no evidence in 1 record (Patient #3) that the plan of care was established and authorized in writing by the physician, and was based on an evaluation of the patient's immediate and long term needs. This resulted in the patient's condition deteriorating, and ultimately an emergency admission to the hospital on 02/02/09. The patient subsequently died on 06/10/09 See G 143 example # 2.  Failure to obtain written physician approval for the patient's comprehensive plan of care has resulted in a negative outcome for patient #3, and has the potential for agency wide negative patient outcomes, and unmet patient needs.  The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 06/08/09. The DPS stated that the agency's procedure had not been followed to ensure that the plan of care was signed within 30 days. See G 143 Example	G 160	G160 Plan of Care  See G118 for process to ensure Plan of Care signed within 30 days  See G250 for QA detail of monitoring Plan of Care signed within 30 days  <i>Accepted 8/11/09 K. Comarthe</i>		

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ST JOSEPHS HOSP HEALTH CENTER CHHA

STREET ADDRESS, CITY, STATE, ZIP CODE

7246 JANUS PARK DRIVE  
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G 160	Continued From page 55	G 160		
G 164	<p>#2.</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE</p> <p>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 27 clinical records, and interviews with the Director of Patient Services (DPS), and Assistant Director of Patient Services (ADPS), there is no evidence in 13 records that the physician is consulted when changes in the patient condition occur. Patients # 1, 3, 4, 5, 6, 8, 15, 20, 22, 23, 24, 26, 27</p> <p>Patient #1 was identified on the 02/2008 - 01/2009 Adverse Event Outcome Report for deteriorating wound status.</p> <p>Patient # 20 was identified on the OBQI Adverse Events Outcome Report for 2/2008 - 1/2009 for emergent hospitalization resulting from a fall.</p> <p>Failure to consult with the physician when changes in the patient's condition occur resulted in a negative outcome for 4 patients, Patients # 1, 3, 20, 22 and has the potential for possible negative patient outcomes agency wide.</p> <p>Examples are as follows:</p> <p>1. Patient #1 was admitted to the agency on 01/18/09. Six Skilled Nurses (SNs) visited the patient daily between the dates of 01/18/09 and 01/24/09, and performed daily dressing changes to the patient's right thigh and scrotum. Although</p>	G 164	<p>G164 Plan of Care</p> <p>See G140 for enhanced Supervision of Plan of care</p> <p>See G168 for education regarding reporting changes in condition and altering the Plan of care</p> <p>See G250 for QA detail of monitoring of reporting changes in condition</p> <p>Patient #1 has been discharged from the agency.</p>	

*accepted 8/14/09*  
*At the meeting*

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G 164	Continued From page 56 the SNs documented that the patient 's thigh wound was deteriorating, none of the SNs reported the changes in the patient 's condition to the physician. As a consequence, on 01/25/09 the patient was admitted to the hospital. The patient required immediate operative debridement and skin graft of the wound for a right thigh abscess, and incision and drainage of right scrotal sac, and IV antibiotics.  - On 01/19/09 the SN documented that the bottom half of the thigh wound bed had blackened tissue which had not been previously documented.  - On 01/20/09 the wound had a slight odor, which had not been previously documented - On 01/21/09 the wound had some odor, and there was a firm area in the patient's right groin, which had not been previously documented - On 01/23/09 the wound had large amount of serous drainage, and the wound was sloughing, which had not been previously documented - On 01/24/09 the wound had signs and symptoms of infection, had blackened drainage, an odor, the surrounding tissue was swollen and painful, and necrotic tissue was present, and the patient 's blood sugar was elevated to 303.  The patient record was reviewed with the Director of Patient Services (DPS) and Assistant Director of Patient Services (ADPS) on 05/28/09. No additional information was provided.  2. Patient #3 was admitted to the agency on 11/5/08 with a history of an admission 3 months prior for severe hypothyroidism. The SN visited the patient several times and failed to recognize deterioration in the patient's condition. The patient was admitted to the hospital on 02/02/09, and	G 164			
				Patient #3 has been discharged from the agency.  <i>Accepted 8/11/09</i> <i>H. McManis</i>	

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G 164	Continued From page 57 subsequently died in a Skilled Nursing Facility on 03/08/09. The SN failed to report the patient's deteriorating status to the physician as follows:  - On 11/5/08, the SN documented that the patient was badly in need of podiatry care, however, documentation is lacking that the SN called the physician and obtained a referral for a podiatrist visit. - On 11/24/08, the SN documented that the patient slept through the visit, despite palpation of his abdomen and milking of the urinary tube. Documentation is lacking that the SN called the doctor to tell him of the patient's lethargic status. - On 12/30/08, the SN stated the patient was sleepy and opened his eyes only when questions were asked. Although the SN reported the patient's blood sugar was low, the SN failed to report the change in the patient's level of consciousness.  The patient was admitted to the hospital on 02/02/09, and subsequently died in a Skilled Nursing Facility on 03/08/09.  The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 05/28/09. No additional information was provided.  3. Patient #22 was admitted to the agency on 05/15/09, and the SN documented in the initial assessment that the patient had a diagnosis of cancer, a new colostomy. On 5/15/09, the SN documented the patient's weight at 168 pounds, and on 5/29/09 the SN documented his weight at 153 lbs. The SN failed to report this 15 lb. weight loss to the physician.	G 164			
				Patient #22 has been discharged from the agency.  <i>Accepted 8/11/09</i> <i>H. Demas</i>	



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G 164	Continued From page 58 The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 06/08/09. No additional information was provided.  4. Patient #20 was admitted to the agency on 11/30/08. The 11/30/08 plan of care included skilled nursing twice a week and physical therapy three times a week.  On 12/16/08 the patient's daughter told the SN that the patient had fallen that day. The SN failed to report the patient fall to the physician, and identify that an updated plan of care was needed to prevent future falls. On 12/23/09 the SN documented in the Patient Activity Log that the patient had fallen again and sustained a fractured hip.  The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 06/08/09. No additional information was provided.	G 164	Patient #20 has been discharged from the agency.		
	5. Patient #15 was admitted to the agency on 04/29/09. The SN failed to report changes in the patient's condition as follows: - On 05/01/09 the patient's left lower extremity measurements were 37.5 - 27.5 - 27.5 cm and on 05/07/09 the measurements were 42 - 30 - 31.5 cm. The SN failed to report an increase of 4.5 - 2.5 - 4 cm respectively. - On 05/07/09 the SN visited the patient and documented the patient had abdominal bruising, which was not previously documented. The SN failed to investigate the possible cause of the bruising and report the change in condition to the physician.		Patient #15: <ul style="list-style-type: none"><li>• RN counseled to report increases in edema to MD per Standard of Care.</li><li>• RN counseled to report changes in patient condition per policy.</li></ul> Patient #15 continued: <ul style="list-style-type: none"><li>• PT counseled to report falls to MD.</li></ul>		

*accepted 8/11/09*  
*A Donath*

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G 164	Continued From page 59 - On 05/18/09 the PT visited the patient and documented the patient had fallen the prior week. Evidence is lacking this was ever reported to the physician.  The patient record was reviewed with the DPS and ADPS. No additional information was provided.	G 164		
G 168	484.30 SKILLED NURSING SERVICES  This CONDITION is not met as evidenced by: o Failure to ensure that skilled nurses are instructed and adequately trained to perform comprehensive nursing assessments which identify each patient's individual needs. Nursing assessments are incomplete and do not consistently reflect the patient's baseline status. See G171  o Failure to consistently reevaluate the patient's condition. See G172  o Failure to coordinate care and services. See G143, G144  o Failure to ensure that skilled nurses receive adequate training and supervision to ensure competency in the skills necessary to develop and implement each patient's plan of care. See G140  The cumulative effect of these systemic issues related to the assessment process resulted in negative outcomes for 7 patients (Patients # 1, 3, 4, 10, 19, 23, 27) and the potential for negative outcomes for the agency's patient population.	G 168	<b>G168 Skilled Nursing Services</b>  <b>See G140 for enhanced Supervision</b>  <b>See G143 and G144 for Coordination of Care</b>  <b>See G250 for QA detail to monitor</b>  Mandatory annual competencies to be completed by all nursing staff. Competencies to be provided to staff by the RN Education Coordinator or the RN Staff Educator under the direction of the PI/Education Manager. Competencies to be completed for all staff by July 30, 2009. Competencies include:  <ul style="list-style-type: none"> <li>• Infection control, hand washing, bag technique</li> <li>• Blood specimen collection</li> <li>• Foley placement and care</li> <li>• Pile dressing change and assessment</li> <li>• Medication prepour</li> <li>• Wound care, inclusive of VAC</li> <li>• In-home supervised wound care and assessment visit</li> </ul>	
G 171	484.30(a) DUTIES OF THE REGISTERED			

*Accepted 8/11/09*  
*J. Demetree*

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G 171	<p>Continued From page 60 NURSE</p> <p>The registered nurse makes the initial evaluation visit.</p> <p>This STANDARD is not met as evidenced by: Based on a review of initial nursing assessments in 27 clinical records, and interviews with Director of Patient Services (DPS), and Assistant Director of Patient Services (DPS) evidence is lacking in 11 records the initial nursing assessments are of sufficient scope to ensure that all patient needs are met. Patients # 3, 7, 10, 12, 13, 14, 17, 19, 21, 23, 25</p> <p>Lack of complete and accurate nursing assessments has the potential for unmet patient needs and possible negative patient outcomes.</p> <p>1. Patient #3 was admitted to the agency on 11/5/08. The Skilled Nurse (SN) performed an initial nursing assessment on 11/5/08. The initial assessment was incomplete or inaccurate as follows:</p> <ul style="list-style-type: none"> <li>- The SN documented that the patient required assistance with medication administration, however, failed to indicate who would be providing the assistance.</li> <li>- The SN documented that there were discrepancies in the patient's medications, and that the SN planned to call the physician to reconcile the medications prior to the next scheduled visit. Although the SN did reconcile the medications with the physician, evidence is lacking the SN ever communicated the correct medications to the SN case manager or the</li> </ul>	G168	<p>Supervised in-home wound care competency mandatory for all nursing staff, including per diem who provide wound care. Supervisory visits to be performed by RN Education Coordinator or the Staff Educator under the Supervision of the PI/Education Manager. In-home wound care supervisory visits on all staff to be completed by July 30, 2009. Competency to include minimum 1 supervised visit while performing wound assessment, providing wound care and includes documentation review. 100% compliance with agency Wound Std required. Unsatisfactory performance prohibits assignment of patients receiving wound care and assessment, formal remediation with possible discipline, repeat in-home visit to demonstrate compliance required until success with 100% competence or disciplinary action up to and including termination.</p> <p>Completion date: May 10, 2009 Responsible person: PI/Education Manager</p> <p>Mandatory re-education of professional staff by ADPS to:</p> <ul style="list-style-type: none"> <li>• Cancelled visit reporting</li> <li>• Reporting patient changes in condition</li> <li>• Documentation guidelines for communicating; discipline-specific algorithms of communication process</li> <li>• Coordinating changes to the Plan of Care</li> <li>• Performance Expectations regarding care planning and care coordination</li> </ul> <p>Completion date: July 13, 2009 Responsible person: ADPS</p>		

Patient #3 has been discharged from  
the agency.

*Accepted 8/1/09  
J. Demas*

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G 171	<p>Continued From page 61</p> <p>patient/caregiver, or specify what the discrepancies were.</p> <ul style="list-style-type: none"> <li>- The SN documented a reported weight of 180 lbs, however, also documented that the patient was confused. The SN failed to identify the weight may have been inaccurate, and confirm the weight with the physician.</li> <li>- The SN documented that the patient/primary caregiver were independent in performing tracheostomy care, and urinary catheter care, however, the SN failed to observe the patient/caregiver performing these functions.</li> <li>- The SN documented the patient needed a podiatry visit, however, failed to identify who was responsible for arranging this.</li> </ul> <p>The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 05/28/09. No additional information was provided.</p> <p>2. Patient # 17 was admitted to the agency on 05/21/09. The SN documented in the 05/21/09 initial nursing assessment 2 decubitus ulcers on the patient's buttocks. The SN failed to measure the ulcers. Additionally, the 05/21/09 plan of care included a primary diagnosis of seizure disorder, however, the SN failed to assess the patient's seizure status, including when his last seizure occurred.</p> <p>The patient record was reviewed with the DPS and ADPS on 06/04/09. No additional information was provided.</p> <p>3. Patient # 21 was admitted to the agency on</p>		<p>Mandatory re-education to all professional Staff by SJHHC Registered Dietician to "Basic Nutritional Assessment," education included:</p> <ul style="list-style-type: none"> <li>• Reasons for nutritional risk</li> <li>• Malnutrition risk in the elderly</li> <li>• Nutritional assessment</li> <li>• Anthropometrics</li> <li>• Weight Change</li> <li>• Prescribed diet</li> <li>• Mode of Feeding</li> <li>• Types of Diets</li> <li>• Nutritional instruction</li> <li>• RD referral</li> </ul> <p>Completion date: July 13, 2009 Responsible person: ADPS PI Coordinator</p> <p>Mandatory re-education of all professional staff by SJHHC Diabetic Educator to "Care of the Diabetic Patient," education included:</p> <ul style="list-style-type: none"> <li>• Assessment of the diabetic patient</li> <li>• Diabetic teaching</li> <li>• Monitoring</li> <li>• ADA glycemic goals</li> <li>• Glycemia and wound healing</li> <li>• Glucometers</li> <li>• Visual impairment</li> <li>• Nutrition</li> <li>• Exercise</li> <li>• Hypoglycemia</li> <li>• Medications</li> </ul>		

*accepted 8/11/09*  
*H. Demetree*

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/27/2009
NAME OF PROVIDER OR SUPPLIER  ST JOSEPHS HOSP HEALTH CENTER CHHA		STREET ADDRESS, CITY, STATE, ZIP CODE 7246 JANUS PARK DRIVE LIVERPOOL, NY 13088		
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G 171	<p>Continued From page 61</p> <p>patient/caregiver, or specify what the discrepancies were.</p> <ul style="list-style-type: none"> <li>- The SN documented a reported weight of 180 lbs, however, also documented that the patient was confused. The SN failed to identify the weight may have been inaccurate, and confirm the weight with the physician.</li> <li>- The SN documented that the patient/primary caregiver were independent in performing tracheostomy care, and urinary catheter care, however, the SN failed to observe the patient/caregiver performing these functions.</li> <li>- The SN documented the patient needed a podiatry visit, however, failed to identify who was responsible for arranging this.</li> </ul> <p>The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 05/28/09. No additional information was provided.</p> <p>2. Patient # 17 was admitted to the agency on 05/21/09. The SN documented in the 05/21/09 initial nursing assessment 2 decubitus ulcers on the patient's buttocks. The SN failed to measure the ulcers. Additionally, the 05/21/09 plan of care included a primary diagnosis of seizure disorder, however, the SN failed to assess the patient's seizure status, including when his last seizure occurred.</p> <p>The patient record was reviewed with the DPS and ADPS on 06/04/09. No additional information was provided.</p> <p>3. Patient # 21 was admitted to the agency on</p>		<ul style="list-style-type: none"> <li>• Insulin</li> <li>• Pharmacokinetics of insulin</li> <li>• Insulin storage</li> <li>• Foot care</li> <li>• Sick day management</li> <li>• DKA</li> <li>• HNK</li> <li>• Documentation</li> <li>• Diabetic educator referral</li> </ul> <p>Completion date: July 13, 2009 Responsible person: ADPS PI Coordinator</p> <p>Wound education/remediation provided by RN Staff Educator and wound audit RN to clinicians identified via auditing process and/or Supervising Nurses as demonstrating persistent lack of understanding re: assessment/planning and provision of wound care, education included:</p> <ul style="list-style-type: none"> <li>• wound assessment expectation</li> <li>• progression of wound care</li> <li>• wound assessment and care documentation</li> <li>• signs/symptoms of infection</li> <li>• MD orders</li> <li>• Physician communication</li> </ul> <p>Completion date: July 22, 2009 Responsible person: ADPS</p> <p>Mandatory education to the "Comprehensive Management of Patients with Wounds" provided to nursing staff by RN wound auditor, education included:</p> <ul style="list-style-type: none"> <li>• Wound assessment expectations</li> <li>• Wound assessment and care documentation</li> <li>• Signs and symptoms of infection</li> <li>• Nutritional needs</li> <li>• MD orders</li> <li>• Physician communication</li> </ul>	

Completion date: July, 19 2009

Responsible person: ADPS

Accepted 8/11/09  
J. DeMott

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/27/2009
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G 171	<p>Continued From page 61</p> <p>patient/caregiver, or specify what the discrepancies were.</p> <ul style="list-style-type: none"> <li>- The SN documented a reported weight of 180 lbs, however, also documented that the patient was confused. The SN failed to identify the weight may have been inaccurate, and confirm the weight with the physician.</li> <li>- The SN documented that the patient/primary caregiver were independent in performing tracheostomy care, and urinary catheter care, however, the SN failed to observe the patient/caregiver performing these functions.</li> <li>- The SN documented the patient needed a podiatry visit, however, failed to identify who was responsible for arranging this.</li> </ul> <p>The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 05/28/09. No additional information was provided.</p> <p>2. Patient # 17 was admitted to the agency on 05/21/09. The SN documented in the 05/21/09 initial nursing assessment 2 decubitus ulcers on the patient's buttocks. The SN failed to measure the ulcers. Additionally, the 05/21/09 plan of care included a primary diagnosis of seizure disorder, however, the SN failed to assess the patient's seizure status, including when his last seizure occurred.</p> <p>The patient record was reviewed with the DPS and ADPS on 06/04/09. No additional information was provided.</p> <p>3. Patient # 21 was admitted to the agency on</p>		<p>Mandatory re-education of professional staff by ADPS and consulting RN to;</p> <ul style="list-style-type: none"> <li>• Case management function and responsibilities</li> <li>• Comprehensive systems assessment</li> <li>• Ongoing reassessment and appropriate follow-up</li> <li>• Reporting, responding to, and monitoring changes in condition</li> <li>• Care coordination amongst care providers</li> <li>• Triggers for Case Conferencing</li> <li>• Communication amongst caregivers</li> <li>• Referral, management and supervision of HHA's</li> <li>• Peripheral medication administration, line management</li> <li>• Patient/caregiver teaching</li> <li>• Inability to Reach Patient policy</li> <li>• Documentation requirements, timeliness</li> <li>• Professional accountability and responsibility, licensure</li> </ul> <p>Completion date: August 10, 2009 Responsible person: ADPS</p> <p><i>Accepted 8/11/09</i> <i>H Demetris</i></p>		

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G 171	<p>Continued From page 62</p> <p>05/08/09. The 05/08/09 plan of care included: a primary diagnosis of traumatic fractured vertebrae, a secondary diagnosis of chronic pain, ultram 50mg every 2 hours as needed for pain, and tylenol 325 mg every 4 hours as needed for pain, neurontin 100mg 3 times per day for pain, which was to be gradually increased to 200 mg 3 times per day by 05/19/09. On 05/08/09 the SN documented in the initial nursing assessment that the patient was experiencing pain at an intensity of 3 of 10, and that the patient reported he needed to call the physician if there was any change in pain level and any reaction to the changing doses of neurontin. The SN, however, failed to assess the pain medication, including the amount the patient was taking.</p> <p>The patient record was reviewed with DPS and ADPS on 06/08/09. No additional information was provided.</p> <p>4. Patient # 14 was admitted to the agency on 04/06/09. The SN documented in the 04/06/09 initial nursing assessment that the patient had stage 2 bilateral decubiti on her buttocks, however, the SN failed to measure the wounds. Additionally, the SN documented the patient had a Peripherally Inserted Central Catheter (PICC) line in her left upper arm, however, failed to measure the external length of the PICC line catheter.</p> <p>The patient record was reviewed with the DPS and ADPS on 06/04/09. No additional information was provided.</p> <p>5. Patient # 10 was admitted to the agency on 04/23/09. The 04/23/09 plan of care included zosyn (antibiotic) via IV infusion every 6 hours</p>	G 171	<p>G171 Duties of the Registered Nurse</p> <p>See G140 for enhanced Supervision of nursing assessments</p> <p>See G168 for education of staff re: performing nursing assessment</p> <p>See G250 for QA detail of monitoring for complete assessments</p> <p><i>accepted 8/11/09 H DeMartino</i></p>	

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G 171	Continued From page 63 through the patients PICC line. The SN failed to perform a complete initial nursing assessment on 04/23/09 as follows:  -The SN documented that she administered SASH (saline-administer medication-saline-heparin flush) per protocol, and that both lumens flushed easily, however, the SN failed to document what medication she administered, the amount of saline she used, and which port was used.  - The plan of care included hydrocodone 10 mg 1-2 tablets for moderate to severe pain every 6 hours as needed for pain. The SN documented the patient was taking pain medication, however, she failed to document the amount or frequency the patient was taking.  - The SN documented the patient had an insulin pump, however, failed to assess the insertion site, or if the patient was able to rotate the sites independently.  The patient record was reviewed with the DPS and Supervising Nurse on 05/28/09. No additional information was provided.	G 171			
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse regularly re-evaluates the patients nursing needs.  This STANDARD is not met as evidenced by: Based on a review of 27 clinical records and interviews with the Director of Patient Services (DPS), and Assistant Director of Patient Services (ADPS) and agency staff, there is no evidence in	G 172			



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G 172	<p>Continued From page 64</p> <p>13 records the Skilled Nursing (SN) reassessments are of sufficient scope to identify changes in the patient's condition which may require re-evaluation and/or modification in the plan of care. Patients # 1, 3, 5, 6, 8, 10, 11, 12, 14, 18, 19, 21, 27</p> <p>Failure to perform complete and accurate nursing assessments has resulted in a negative outcome for patients # 1,3,19, 23, and 27, and has the potential for agency wide unmet patient needs.</p> <p>Patients #1 and 19 were identified on the 02/2008 - 01/2009 Adverse Event Outcome Report for deteriorating wound status.</p> <p>Examples are as follows:</p> <p>1. Patient # 27 was admitted to the agency on 09/09/08. On 03/06/09 the SN conducted a comprehensive recertification nursing assessment. The 03/08/09 updated plan of care included SN visits 2 times per week for 8 weeks for wound care, foley catheter maintenance, and assessment .</p> <p>Although the patient called the agency for help on 04/27/09, the agency failed to conduct follow up assessments with the patient. Two days later, on 04/29/09 the patient was found on the floor by a lab technician who was assigned to draw blood. The patient was transported to the hospital by 911 responders. The patient had been pinned to the floor at home for 2 days, despite having called the agency for help on 04/27/09.</p> <p>The patient subsequently died on 06/10/09. The 06/10/09 hospital physician discharge summary upon the patient's death stated "Chief Complaint:</p>	G 172	<p><b>G172 Duties of the Registered Nurse</b></p> <p><b>See G140 for enhanced Supervision</b></p> <p><b>See G143 and G144 for Coordination of Care detail</b></p> <p><b>See G168 for education for nursing assessments</b></p> <p>Agency policy developed regarding procedure with specific steps to be taken for when a patient does not appear to be home i.e. doesn't answer the phone or door. Policy to include when to attempt a visit, when to contact the emergency contact, communication of inability to reach patient to emergency contact and to the ordering physician. All Agency visit staff to be educated to the new policy and expectations.</p> <p>Completion date: August 17, 2009 Responsible person: DPS</p> <p>Patient #27 has been discharged from the agency.</p> <p><i>accepted 8/11/09 H Demant</i></p>		

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G 172	<p>Continued From page 65</p> <p>Difficulty breathing....The patient's difficulty breathing apparently began about a month ago in association with her falling at home. The patient was down for approximately 40 hours, and was unable to get up...the patient deceased on 06/10/09"</p> <p>Specifically, the 04/29/09 admitting history and physical by the hospital physician documented that on the night of 04/27/09 the patient felt weak, and she had fallen to the floor, "She was unable to get up...she lives alone in an apartment... she was yelling all day Tuesday (04/28/09)...she was unable to get to the phone...she remained on the floor until Wednesday morning (04/29/09)...she was also weak Sunday (04/26/09) night and fell, requiring the fire department to come help her. The 04/29/09 emergency medical services record documented that the patient: "had been lying on the bedroom floor for 2 days... had a dresser drawer across her thigh... was confused... had a cyanotic face." The 04/29/09 note by the hospital physician also documented the patient was admitted with "pneumonia, dehydration, acute renal failure, urinary tract infection, weakness. ..."</p> <p>The SN case manager visited the patient 5 times between 03/06/09 and 04/13/09. The SN failed to conduct accurate and complete assessments as follows:</p> <ul style="list-style-type: none"> <li>- On 03/06/09 the SN case manager conducted a comprehensive re-certification assessment and documented that the patient was at risk for falls, and could not be left alone. The SN failed to document who was living with the patient, and on 03/27/09 the LPN visited the patient and documented that the patient was living alone. The SN failed to identify that the patient was in an</li> </ul>	G 172			

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NAME OF PROVIDER OR SUPPLIER

ST JOSEPHS HOSP HEALTH CENTER CHHA

STREET ADDRESS, CITY, STATE, ZIP CODE

7246 JANUS PARK DRIVE  
LIVERPOOL, NY 13088

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G 172	<p>Continued From page 66</p> <p>unsafe situation.</p> <p>- The SN failed to assess for the need of Home Health Aide (HHA) services. Specifically, on 10/06/08 the social worker documented that the patient was applying for medicaid, and had a privately hired caregiver 3 hours per day, 5 days per week. Evidence is lacking the SN case manager ever assessed if the patient was in need of HHA services, or discussed with the social worker the patient's financial needs and HHA needs. As a result, this patient, who had limited financial resources, was compelled to pay for her own personal care assistance.</p> <p>On 03/06/09 the SN case manager documented: the patient: was confused, had impaired decision making, required assistance with bathing, and dressing, had a privately hired aide. The SN failed to assess if the patient required additional services of an agency HHA to meet her personal care and safety needs.</p> <p>During the 07/09/09 interview with the SN case manager, the SN stated to the surveyor: she was sure the patient's needs were being met because the patient had told her so, she did not know why the agency was not providing a HHA for the patient because that had been determined prior to her taking over as the case manager (on 03/02/09). The SN failed to identify that it was her responsibility as the case manager to assess if all of the patient's needs were being met, including if the patient required HHA services from the agency. Instead the SN relied on the patient, who was confused, and had impaired decision making to make this determination.</p> <p>During the 07/13/09 interview with the patient's</p>	G 172		

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G 172	<p>Continued From page 67</p> <p>daughter, the daughter told the surveyor that the agency had never offered the services of a HHA, and that if they had been offered, she and her mother would have "most definitely" accepted them.</p> <p>- The SN failed to identify that the patient required an wheelchair for mobility, until the patient's 04/27/09 phone call to the agency, when the patient reported that she could not transfer from the toilet to the wheelchair.</p> <p>- The SN failed to assess the patient's ability to call for help if needed, and for the possible need of a Personal Emergency Response System (PERS). On 10/06/09 the social worker visited the patient and documented that the patient had a PERS, and on 03/06/09 the SN case manager documented that the patient was able to walk only with the supervision or assistance of another person at all times, could transfer herself, had a fear of falling. The SN case manager failed to: assess how the patient was able to mobilize when the private caregiver was not present, assess if the patient had a PERS, and if so, if the patient was able to use it properly.</p> <p>On 07/09/09 the surveyor interviewed the social worker and the SN case manager. The social worker stated she could not remember how she identified that the patient had a PERS. The SN case manager stated she did not know if the patient had a PERS, but thought that the patient "would have probably activated it, if she had one, the night of her fall".</p> <p>On 07/13/09 the surveyor interviewed the patient's daughter. The daughter stated that the patient did not have a PERS, and that the patient</p>	G 172			

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G 172	<p>Continued From page 68</p> <p>wore her cordless phone around her neck. The daughter stated that her mother must not have been wearing it the night she fell.</p> <p>- The SN failed to re-assess the patient even when the patient called the agency on 04/27/09 reporting she was "stuck on the toilet", and that she had also fallen the night before. As a result the patient helplessly remained on the floor for two days after falling, unable to take her medications, including insulin and anticoagulant therapy, eat, or drink, to ensure that the patient received life saving emergency medical services immediately following a fall. As a result the patient was forced to remain on the floor for two days after falling for a second time in a 24 hour period.</p> <p>Specifically, on 04/27/09 at 4:30 PM the SN case manager documented in the Patient Activities Log that the patient had called to report she was stuck on the toilet, and had been trying to get to her wheelchair for 2 1/2 hours. The SN instructed her to call 911, and the patient replied that she just called them the prior night after falling. The SN replied that she was not aware of this, and that the patient told her that "I haven't had time to let you know". The patient agreed to call 911, and the SN told the patient "we would place call this evening to follow up." The SN documented that she reported the situation to the evening coordinating RN.</p> <p>Both of the SN case manager, and SN evening coordinator, failed to ever followed up with the patient, and 2 days later, on 04/29/09 the patient was admitted to the hospital on an emergent basis after being found on the floor by a lab technician. The 03/08/09 plan of care documented that the patient was diabetic, and</p>	G 172			

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G-172	<p>Continued From page 69</p> <p>included Glargine insulin 1 time per day and novolog insulin 2 times per day, Januvia (oral hypoglycemic) daily, coumadin (blood thinner) daily, lasix (diuretic) daily, all of which the patient was unable to take during the 2 days she was on the floor. The 04/29/09 emergency medical services record documented that the patient: had been lying on the bedroom floor for 2 days, had a dresser drawer across her thigh, was confused, had a cyanotic face upon their arrival.</p> <p>The SN failed to followed up with the patient until 04/29/09. On 04/29/09 a different SN documented she had made 4 phone attempts to contact the patient between the times of 10:45 AM and 2:00 PM, and attempted a visit at 2:45 PM. The SN documented that during the attempted visit, the apartment building staff reported that the patient had already been taken to the hospital. The SN stated that it is agency policy to make 3 phone attempts and then visit the patient, however on 07/16/09 the DPS emailed the surveyor stating that the agency has no formal policy.</p> <p>The patient record was reviewed with the Administrator, DPS, ADPS, and Supervising Nurse on 07/16/09. The DPS submitted the SN case manager's cell phone log for 04/27/09 and 04/28/09. The log contained 5 phone calls on 04/28/09 to the patient. Four of the phone calls were for 1 minute, and 1 call was for 2 minutes. The DPS told her that she did speak with the patient at 10:30AM during the 2 minute call, and the patient declined a visit. The daughter, however, informed the surveyor otherwise. The daughter daughter stated that there were 2 phone messages on the patient's answering machine from the agency on 04/28/09, one of which was</p>	G 172			

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G 172	<p>Continued From page 70</p> <p>from the SN case manager at approximately 10:30 AM. The message was detailed, and included the case manager stating that she was in the lobby (of the patient's apartment building), and that she spoke to people at the front desk. They said that they had seen you (the patient), and that you are fine.</p> <p>Additionally, the daughter stated that on 04/29/09 a third SN left a message. The daughter said that during the first message, the SN specifically said that "we never connected with you yesterday, and that she would try and catch up with the patient later".</p> <p>Additionally, the daughter stated that the agency was aware that the door of the patient's apartment was always left open to allow access for all caregivers, and that she had instructed the agency to visit the patient, whether or not she answers the phone. During the 07/09/09 interview by the surveyor of the SN case manager, the case manager confirmed this to be true.</p> <p>Following the conclusion of the record review, the surveyor requested a policy of the agency's procedure when a patient is not found at home, and fails to answer the phone for a follow up visit. On 07/16/09 the DPS responded via e-mail, indicating the agency does not have a written policy with specific steps that should be taken, including contacting emergency contacts, and reporting to the physician.</p> <p>2. Patient #1 was admitted to the agency on 01/18/09. The plan of care included: the patient was to check blood glucose 2 times per day, and report values greater than 350 to the physician, daily dressing changes to a wound located on the</p>	G 172			

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G 172	<p>Continued From page 71</p> <p>patient.' s right thigh. Between the dates of 01/18/09 and 01/24/09 (7 days), the patient record included daily visits by 6 different SNs to perform the dressing changes and wound assessment. Evidence is lacking the SNs performed complete and accurate nursing assessments, and as a result failed to identify the wound was deteriorating, which resulted in emergent hospitalization of the patient for wound infection. Specifically, the SNs failed to:</p> <ul style="list-style-type: none"> <li>- Measure the patient ' s thigh wound. Specifically, the SN documented on 01/21/09 and 01/22/09 that the wound was large, however, the SNs failed to measure the wound, which would have been an objective finding to indicate if the wound was deteriorating.</li> <li>- Measure the necrotic area of the wound. Specifically, the 01/18/09 initial nursing assessment documented that the wound bed was yellow, the 01/19/09 SN assessment indicated the bottom half of the wound bed had blackened tissue, the 01/20/09 SN documented the wound bed was black in some areas, on 01/22/09 the SN documented the wound was " covered with eschar/scab. ? " Evidence is lacking the SNs obtained objective findings to assess if the necrotic area was new, or worsening.</li> <li>- Accurately assess the patient's right leg edema. Specifically, on 01/22/09 the SN documented she reported mild non pitting edema to the physician. On the following day (01/23/09) a different SN documented 1-2 plus non pitting edema. Evidence is lacking the SN understood that by grading the edema as 1-2 plus, this indicated the edema was now pitting, and that the edema had worsened.</li> <li>- Assess the temperature of the area surrounding the wound, specifically, if the area was warm to</li> </ul>	G 172			



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G 172	<p>Continued From page 72</p> <p>touch, which would have been a sign of infection</p> <p>- Assess the type and amount of pain medication the patient was taking. Specifically, the plan of care included oxycodone/acetaminophen 5/325 mg 1-2 tablets every 6 hours as needed for pain, and acetaminophen 325mg, 2 tabs for mild pain 3 times per day as needed. From 01/18/09-01/24/09, the SNs documented at every visit that the patient was experiencing leg pain, and was taking pain medication, however the SNs failed to assess the amount, type, or frequency of pain medication the patient was taking, or if the patient was exceeding the maximum daily dose for acetaminophen (4000 mg). By failing to do this the SNs were unable to accurately assess if the patient's pain status was worsening.</p> <p>Additionally, during the same daily visits the SNs documented the patient's temperature ranged from 96.4 to 99.4. The SNs failed to identify the 3 degree range in temperature as a potential patient problem, and failed to assess when the patient last took the acetaminophen relative to the temperature value, which would have affected the accuracy of the patient's temperature</p> <p>- Assess the patient's blood sugars. Specifically, on the 01/18/09 initial assessment, the SN failed to assess the patient's blood sugar and documented that the patient needed a new glucometer. On 01/19/09, 01/20/09, 01/21/09 the SN failed to assess blood sugar level. On 01/22/09 the SN documented the patient's blood glucose as 327, and on 01/23/09 as 285, and on 01/24/09 as 303. Although the SN instructed the patient to bring his log to the physician, the SN failed to assess that the patient's blood sugar was consistently elevated, and failed to report this to the physician.</p>	G 172			

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G 172	<p>Continued From page 73</p> <p>- Assess the patient 's groin. Specifically, on 01/21/09 the SN documented the patient had a " firm area in the right groin." Evidence is lacking the SN identified this as a possible sign of infection, or that the SNs ever reassessed this.</p> <p>- Assess the patient's scrotal wound. Specifically, on 01/22/09 the SN assessed that the scrotal wound was draining. Although the SNs visited the patient on 01/23/09 and 01/24/09, the SN failed to reassess the scrotal wound.</p> <p>On 01/23/09 the SN documented that the thigh wound had a large amount of serous drainage and that the wound was sloughing, which was not previously documented, and on 01/24/09 a different SN documented the wound had blackened drainage, an odor, swelling and pain. Evidence is lacking either SN identified these as symptoms of wound deterioration which required immediate medical intervention.</p> <p>The hospital record documents that on admission 1/25/09 the patient had blood sugars at home of upper 300 's and 400 's, had foul smelling drainage from wound, soft tissue swelling, right lower extremity swollen, right upper thigh swollen and fluctuant (moveable mass), fluid collection in right scrotal wall, right groin purulent drainage, right scrotum tenderness, foot cool and blanched. The patient required immediate operative debridement and skin graft of the wound for right thigh abscess , and incision and drainage of right scrotal sac, and IV antibiotics.</p> <p>The patient record was reviewed with the DPS and ADPS on 05/28/09. No additional information was provided.</p>	G 172			

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G 172	<p>Continued From page 74</p> <p>3. Patient #3 was admitted to the agency on 11/05/08. Although the SN visited the patient 4 times between 11/11/08 and 12/30/08, the reassessments were incomplete or inaccurate which resulted in the SN failing to recognize that the patient's condition was deteriorating. As a result, the patient's condition deteriorated significantly, and the patient was admitted to the hospital on 02/02/09. The 02/02/09 emergency medical services record, and hospital emergency room record documented that the patient was admitted with lice and bedbugs, covered in feces, and had a stage 2 sacral decubitus. The hospital record also documented that the patient was severely hypothyroid, and the Primary Care Physician (PCP) documented on 02/05/09 that the patient was emaciated with an approximate weight loss of 50 - 60 lbs. The patient subsequently died in a Skilled Nursing Facility on 03/08/09. Specifically,</p> <p>On 11/05/08 initial nursing assessment documented that the patient was able to participate in bathing himself in the shower or tub, and the patient could transfer himself with minimal assistance or with the use of an assistive device. The SN failed to ever reassess the patient's ability to ambulate or to perform activities of daily living until 8 weeks later, on 12/30/08.</p> <p>- On 11/24/08, the SN documented that the patient slept through the visit, despite palpation of his abdomen and milking of the urinary tube.</p> <p>- On 12/30/08 the SN documented in the recertification assessment that the patient could</p>	G 172	<p>Patient #3 has been discharged from the agency.</p> <p><i>accepted 8/11/09 H. Demarsh</i></p>	

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G 172	<p>Continued From page 75</p> <p>no longer use the shower or tub and was now being bathed in bed or bedside chair, that the patient was no longer able to transfer himself and was now only able to pivot, the patient was sleepy and opened his eyes only when questions were asked. The SN; however, failed to recognize the patient's level of consciousness, and general medical status had deteriorated.</p> <p>On 05/27/09 the surveyor interviewed the SN case manager, the SN stated that she never actually observed the patient's ambulation as he was always in bed for his foley change when she visited.</p> <p>The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 05/28/09. No additional information was provided.</p> <p>4. Patient # 23 was admitted to the agency on 04/03/09, and the patient resided in an Adult Home. The 04/03/09 plan of care documented that the patient had an indwelling urinary catheter and the SN was to visit daily for wound care, and assess genito-urinary status. The SN reassessments were incomplete or inaccurate, resulting in the patient being hospitalized for dehydration as follows:</p> <p>- The SN visited the patient daily from 04/03/09 to 05/18/09, and documented that the patient stated that he was drinking adequate fluids, however, the SN also documented that the patient was confused, but failed to question the Adult Home staff about the patient's fluid intake.</p> <p>Additionally, the SN assessed during the same visits that the urinary catheter was draining,</p>	G 172	<p>The nurses and managers involved during this time period were all given specific items cited to review, review of expected guidelines for assessment, and reference to policy. Counseling documented.</p> <p><i>accepted 8/11/09</i> <i>St Demetrius</i></p>		

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G 172	<p>Continued From page 76</p> <p>and/or the urine was clear yellow, however, with the exception of 04/06/09, the SN failed to ever assess the amount of urine output, and/or if the patient's urine output was sufficient.</p> <p>- On 05/15/09 the SN visited the patient and documented that the patient's urine was copper colored. Although the SN reported this to the physician, the SN failed to reassess the patient's urinary status until 3 days later on 05/18/09, and failed to assess the patient's fluid intake.</p> <p>- On 05/18/09 the patient was admitted to the hospital on an emergent basis for dehydration as documented in the Patient Activity Log.</p> <p>The patient record was reviewed with the DPS and ADPS on 06/09/09. No additional information was provided.</p> <p>5. Patient #19 was admitted to the agency on 01/29/09. On 2/13/09 the patient had an elective amputation of necrotic great toes of both feet in the physician's office. The SN failed to attempt to visit the patient until 02/17/09 which was 4 days following the surgery, to assess the surgical site, and contact the physician for an updated plan of care following the surgery.</p> <p>On 02/17/09 the SN documented the patient had been admitted to the hospital on 02/14/09 for a wound infection.</p> <p>The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 06/04/09. No additional information was provided.</p>	G 172	<p>RN no longer employed by CHHA; unable to remediate.</p> <p>Patient #19 has been discharged from the agency.</p> <p><i>Accepted 8/11/09</i> <i>H. Demarino</i></p>		

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G 172	<p>Continued From page 77</p> <p>HV</p> <p>6. Patient # 14 was admitted to the agency on 04/06/09. The 04/06/09 plan of care included continuous infusion of total parental nutrition via a Peripherally Inserted Central Catheter (PICC) line. The nursing re assessments were inaccurate or incomplete as follows:</p> <ul style="list-style-type: none"> <li>- On 05/21/09 the physician documented that the patient had a new PICC line placed which had 0 cm external catheter length. On 05/22/09 the SN visited the patient, however, failed to assess the external length of the catheter.</li> <li>- On 05/22/09 the SN visited the patient and documented that the PICC line had 1 cm of external catheter length. The SN failed to assess that the PICC line had migrated, or identify that the physician had not been notified.</li> <li>- On 06/02/09 the surveyor made an observational home visit with the SN. During the visit, the surveyor reviewed the notes of the privately hired caregivers which documented that on 05/23/09 the patient's daughter called the agency to report blood at the PICC line site which was not previously noted, and requested a visit by the SN. The documentation stated that the agency responded that they could not spare a nurse that day "unless it was real bad," and if the situation worsens to contact them and someone will visit. The patient record confirmed that on 05/23/09 the agency received a phone call from the daughter to report blood under the PICC line dressing, however, there was no visit made.</li> </ul> <p>The SN failed to visit the patient until 3 days later on 05/26/09, and on 05/26/09 failed to assess for bloody drainage at the PICC line site.</p>	G 172	<p>Patient #14 has been discharged from the agency.</p> <p>Advisory RN who responded inappropriately to patient call regarding PICC line was counseled.</p> <p>Completion date: June 6, 2009</p> <p>Responsible person: Supervising Nurse</p> <p><i>Accepted 8/11/09</i> <i>H Demarcus</i></p>	

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G 172	<p>Continued From page 78</p> <p>The patient record was reviewed on 06/04/09 with the DPS and ADPS. No additional information was given.</p> <p>7. Patient # 5 was admitted to the agency on 03/05/09. The plan of care included acetaminophen 325 mg 2 tabs 3 times per day as needed for mild pain, and hydrocodone/acetaminophen 5 mg/500mg every 4 hours as needed for moderate to severe pain. The SN failed to adequately assess the amount and type of pain medication the patient was taking, or if the patient was exceeding the maximum daily dose for acetaminophen, which is 4000 mg per day, per the Nursing 2007 Drug Handbook (see attached), as follows:</p> <ul style="list-style-type: none"> <li>- On the following dates the SN assessed that the patient was experiencing pain, however, failed to assess the type or amount of pain medication the patient was taking on 03/06/09, 03/07/09, 03/10/09, 03/13/09</li> <li>- On 03/12/09 the patient record contained documentation of a phone call from the physician to the SN to report that the patient had been taking hydrocodone every 2 hours at times, and the physician requested that the SN monitor the patient's usage of this medication. Although the SN documented on 03/14/09 that the patient did not take more medication than prescribed, the SN failed to assess specifically the type and amount of pain medication the patient was taking.</li> <li>- On 04/05/09 the SN documented the patient was experiencing pain at a level of 5 of 10, and the pharmacy did not deliver the patient's pain medication on the prior day, but the patient could</li> </ul>	G 172	<p>RN counseled regarding medication review and safety, in particular acetaminophen.</p> <p>Nurse is on LOA, not currently working.</p> <p><i>Accepted 8/11/09</i> <i>H. Demarino</i></p>	

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G 172	Continued From page 79 use tylenol if needed. The SN failed to assess: the amount of hydrocodone the patient had been taking, why he was running out of pain medication, the potential for acetaminophen toxicity.  - On : 04/ 07/09, 04/08/09, 04/24/09, 05/ 01/09, 05/03/09, 05/05/09,05/15/09 the SN documented the patient was taking pain medication, however, despite the physician's verbal order to assess the patient's hydrocodone intake, the SN never assessed the type or amount of pain medication the patient had been taking  The patient record was reviewed with the DPS and ADPS on 06/03/09. No additional information was provided.	G 172		
G 229	484.36(d)(2) SUPERVISION  The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.  This STANDARD is not met as evidenced by: In 8 of 8 clinical records reviewed, where the patient was receiving Home Health Aide (HHA) services for greater than 2 weeks, and interviews with the Director of Patient Services (DPS), and Assistant Director of Patient Services (ADPS), the Skilled Nurses (SNs) failed to provide adequate supervision to the Home Health Aides (HHA). Specifically, the SNs have failed to: - supervise the HHAs every 2 weeks - review care plans with the HHAs - observe the HHAs performing care, as required by the agency's 05/2009 HHA Clinical	G 229	<b>G229 Supervision</b>  <b>See G168 for education</b>  Agency professional staff to be re-educated to HHA service utilization and supervision by ADPS. Education to include: <ul style="list-style-type: none"><li>• HHA scope and services</li><li>• HHA referral process</li><li>• HHA care plan development that encompasses all the patient's needs and provides the aide with a clear plan and parameters for which to notify the RN Case Manager or Supervising RN</li><li>• Monitoring and updating the HHA care plan to meet changing patient needs</li><li>• HHA supervisory requirements, including orientation, observation and q 14 day in-home supervision</li><li>• Ongoing supervision and monitoring of HHA following the HHA care plan</li></ul>	

*Accepted 8/11/09  
H. DeMonte*



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NAME OF PROVIDER OR SUPPLIER

ST JOSEPHS HOSP HEALTH CENTER CHHA

STREET ADDRESS, CITY, STATE, ZIP CODE

7246 JANUS PARK DRIVE  
LIVERPOOL, NY 13088

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G 229	<p>Continued From page 80 Supervision Policy.</p> <p>Patients # 4, 5, 8, 11, 12, 14, 15, 21</p> <p>Failure of the agency to provide adequate supervision to Home Health Aides has the potential for unmet patient needs, and possible negative patient outcomes.</p> <p>Examples are as follows:</p> <p>HV 1. Patient #12 was admitted to the agency on 03/25/09. On 05/28/09 the surveyor made an observational home visit with the SN. During the visit the patient's daughter stated that the patient had recently been experiencing a lot of pain in the due to tension on the indwelling urinary catheter, and that the aides do not seem to know how to anchor the catheter correctly on the patient's thigh. The SN failed to:</p> <ul style="list-style-type: none"> <li>- supervise the HHA every 2 weeks. Specifically, although the patient began to receive HHA services on 03/27/09, the only aide supervision provided by the SN was on 04/27/09 and 05/20/09</li> <li>- update the aide care plan with specific instructions for the HHA on how to anchor the catheter</li> <li>- review the care plan with the HHA, and observe if the HHA was performing care correctly, until the observational home visit on 05/28/09.</li> </ul> <p>The patient record was reviewed with the DPS and ADPS on 06/08/09. No additional information was provided.</p>	G 229	<ul style="list-style-type: none"> <li>Communicating with Supervising Nurse, HHA Manager, and physician re: patient's personal care needs and specifics of HHA service as approp.</li> <li>HHA supervisory staff to inform RN Case Manager and Team Manager whenever a supervision is missed. It it's the responsibility of the Team Manager to implement a plan to perform a supervision and to assure compliance going forward.</li> <li>Staff who fail to consistently comply with a 14 day HHA supervision requirement will be counseled and disciplined as appropriate.</li> </ul> <p>Completion date: August 10, 2009 Responsible person: ADPS</p> <p>Patient #12, Updated HHA care plan with specific instructions for the HHA on how to anchor the catheter.</p> <p>Page #12, Nurse counseled re: development of the HHA care plan and HHA supervision requirement.</p> <p><i>accepted 8/11/09</i> <i>A. Komaruk</i></p>	

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NAME OF PROVIDER OR SUPPLIER  ST JOSEPHS HOSP HEALTH CENTER CHHA			STREET ADDRESS, CITY, STATE, ZIP CODE 7246 JANUS PARK DRIVE LIVERPOOL, NY 13088	
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G 229	<p>Continued From page 81</p> <p>HV</p> <p>2. Patient # 11 was admitted to the agency on 5/2/09. The 05/02/09 plan of care included HHA services 3 times per week for 3 weeks.</p> <p>On 5/28/09 the surveyor made an observational home visit with the SN. During the visit, the patient's wife stated that she was overwhelmed and that the home health aide had "just stopped coming two weeks ago". The SN failed to:</p> <ul style="list-style-type: none"> <li>- supervise the HHA every 2 weeks. Specifically, the SN failed to make any HHA supervisory visits until 05/28/09.</li> <li>- ensure that the HHA followed the plan of care. Specifically, although the SN visited the patient on 05/21/09, the SN failed to identify that the HHA had not visited the patient since 05/15/09, investigate why, and report this to the supervising nurse and physician.</li> </ul> <p>The patient record was reviewed with the Director of Patient Services and the Assistant Director of Patient Services on 06/04/09. No additional information was provided.</p> <p>3. Patient # 5 was admitted to the agency on 03/05/09. The 03/05/09 initial nursing assessment documented that the patient required a higher level of care, however, refused to go to the emergency room. The SN assessed that the patient's safety and personal care needs could be met by the provision of daily HHA services, which the family, patient, and physician agreed to, and this was included in the 03/05/09 plan of care. The SN failed to:</p>	G 229	<p>Patient #11 has been discharged from the agency.</p> <p><i>Accepted 8/11/09</i> <i>J. Domestino</i></p>	

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7246 JANUS PARK DRIVE  
LIVERPOOL, NY 13088

accepted 8/11/09  
H. Demaree

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G 229	Continued From page 83 - instructions specifying the patient was to be wearing an arm protector per the 05/08/09 CMS - 485 plan of care.  The patient record was reviewed with the ADPS and DPS on 06/08/09. No additional information was provided.  5. Patient # 15 was admitted to the agency on 04/29/09. The 04/29/09 plan of care included HHA services 2 times per week for 1 week, then 3 times per week for 3 weeks. Although the SN documented supervisory aide visits on 05/06/09, 05/21/09, and 06/01/09, the aide was not present for any of the visits. The SN failed to ever observe the HHA performing care, or review the care plan with the aide per the agency's 05/2009 HHA Clinical Supervision Policy.  The patient record was reviewed with the DPS and ADPS on 06/03/09. No additional information was provided.	G 229	Patient #15 HHA service discontinued as of 05/29/09.  <i>Accepted 8/11/09</i> <i>J. R. M. [Signature]</i>		
G 242	484.52 EVALUATION OF THE AGENCY'S PROGRAM  This CONDITION is not met as evidenced by: The agency failed to implement a program which identifies and resolves problems associated with quality patient care. Specifically, the agency failed to conduct an annual program evaluation for 2008, and failed to identify problem areas in patient care and develop mechanisms for resolutions. Specifically, the agency failed to ensure and evaluate the following:  o The extent to which the agency's program is appropriate, adequate, effective and efficient. See	G 242			

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G 242	Continued From page 84 G 243  o The adequacy of nursing supervision and supervision of paraprofessional staff. G140, G 229  o The effectiveness of case management and physician notification/consultation. G143, G144, G160, G164  o The accuracy and completeness of patient assessments and reassessments G171, G 172  o The agency's ability to develop and implement plans of care which address each patient's needs and assists the patient in reaching established goals G158, 159  o The agency's compliance with all applicable federal, state, and local laws and regulations. G 118  o The quality and appropriateness of patient care. See G250  The cumulative effect of the agency's failure to adequately assess the agency's services and identify systemic problems resulted in the home care agency's inability to ensure the provision of quality care and a negative outcome for nine patients (# 1, 3, 4, 6, 10, 19, 20, 22, 23), and the potential for negative outcomes for the agency's entire patient population.	G 242	G242 Evaluation of the Agency's Program  See G243 for Program Evaluation detail  See G250 for QA/PAC/Governing body detail  The Agency will hold a PAC meeting and present 2009 DOH survey results and the applicable Plan of correction. All deficiencies and Plans to address will be presented, open for discussion, and approval with PAC members.  Presentation to include comparison of Agency Evaluation pre and post survey. Survey and self-identified deficiencies in practice and organizational processes will be presented. Audit and oversight activities addressing accuracy and completeness of assessments and reassessments, appropriateness and following of Plans of Care, compliance with federal, state, and local law and regulation, and quality and effectiveness of care will be also be presented and open for discussion. Agency changes to supervision, assessment and audit of care and services provided and the Agency plan for ongoing compliance and goals going forward will be presented. A plan will be developed for ongoing Annual Evaluation by the PAC that includes adequacy of nursing supervision, effectiveness of case management, physician consultation, accuracy and completeness of assessments and Plans of Care, compliance with federal, state and local law and regulation, and the overall quality and effectiveness of patient care. Evidence of the 2009 Evaluation and the	
G 243	484.52 EVALUATION OF THE AGENCY'S PROGRAM  The HHA has written policies requiring an overall evaluation of the agency's total program at least		plan for ongoing Evaluation will be in the August 2009 PAC report and meeting minutes.	

Completion date: August 12, 2009  
Responsible person: Administrator  
DPS

*Accepted 8/11/09  
H Demasthe*

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G 243	Continued From page 85 once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers.  This STANDARD is not met as evidenced by: Based on interviews with the Director of Patient Services, Assistant Director of Patient Services, and a review of agency Professional Advisory Committee (PAC) meeting minutes, and Governing Body meeting minutes for the past 12 months there is no evidence that the PAC is conducting an overall evaluation of the agency's total program program at least once a year, and there is no evidence the agency maintains a policy which requires a yearly evaluation, and specifies what components should be included.  Specifically, on 06/16/09, the surveyor requested the minutes for the yearly Annual Agency Evaluation. The DPS stated that the Governing Body was scheduled to review the agency's 2008 performance on January 2009, however, it did not take place, and was rescheduled for September 2009. The DPS submitted a document dated 11/13/07 titled "Executive Summary Report" which included the agency's presentation to the Governing Body of it's 2007 accomplishments and 2008 goals. There has been no overall agency evaluation in the past 12 months by the PAC, or a committee of the PAC.		The Administrator will present the Evaluation, PAC report, and plan for ongoing Annual Evaluation to the Board of Directors for discussion and input.  Completion date: August 28, 2009 Responsible person: Administrator  G243 Evaluation of the Agency's Program  See G242 Program Evaluation detail  The Agency has a policy specific to Annual Program Evaluation. The policy has been in existence since 1998 and reviewed/revised annually since 2001. The policy was not requested at time of survey. Policy reviewed, revised and presented to be the for approval. Policy includes the following:		
G 250	484.52(b) CLINICAL RECORD REVIEW  At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether	G 250	<ul style="list-style-type: none"> <li>Policy review to be in quarterly increments by members of the PAC and reported to the PAC quarterly. The Administrator will present the policies to the Board of Directors Executive Committee quarterly</li> <li>Clinical record review to be completed quarterly by members of the PAC and disciplines representing services provided, on a sample of open and discharged records. Record review results will be presented to the PAC quarterly. The Administrator will present results to the Board of Directors Executive Committee quarterly.</li> </ul>		

Accepted 8/11/09  
W. Depina

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G 250	<p>Continued From page 86:</p> <p>established policies are followed in furnishing services directly or under arrangement.</p> <p>This STANDARD is not met as evidenced by: Based on a review of the agency's Quality Improvement Program, Professional Advisory Committee (PAC) meeting minutes, Governing Body meeting minutes and interviews with the Director of Patient Services (DPS), Assistant Director of Patient Services (ADPS), and Quality Improvement Nurse, the agency's Quality Improvement program failed to:</p> <ul style="list-style-type: none"> <li>- Self identify issues with quality of care, and compliance, as documented in this report</li> <li>- Report all trended results to the PAC for the development of action plans</li> <li>- Ensure that the PAC develops action plans when they are presented with statistical evidence of problems</li> <li>- Ensure that the Governing Body reviews problems identified by the Quality Improvement Committee, and reviews the plans developed by the PAC committee to resolve the problems.</li> </ul> <p>Failure of the agency to have an effective Quality Improvement program has resulted in negative outcomes for 9 patients. Patients # 1, 3, 4, 10, 19, 20, 22, 23, 27 and has the potential for agency wide negative patient outcomes, and unmet patient needs.</p> <p>Examples are as follows:</p> <p>1. The QI committee failed to self identify issues with quality of care, and compliance as documented in this report. Specifically, the QI committee documented the following audit</p>	G 250	<ul style="list-style-type: none"> <li>An Annual Assessment for overall quality, appropriateness, effectiveness and efficacy of the program to be done by members of the PAC, agency employees, at least one consumer, a physician, and agency administrative staff. The Administrator will present the overall assessment to the Governing Body each year. The 2009 Annual Assessment will be presented to the PAC and Governing Body in Septemeber.</li> </ul> <p>Completion date: August 12, 2009 Responsible person: DPS</p> <p><b>G250 Clinical Record</b></p> <p>Professional Advisory Committee meeting frequency changed to monthly effective August 2009. Committee charter to be revised at August meeting to include active participation by committee members in Agency assessment and quality improvement activities, including, but not limited to, record review and Action Plan development for identified negative trends. PAC</p>		

*Accepted 8/11/09  
J. Remarke*

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G 250	<p>Continued From page 87</p> <p>results for the 4 quarters of 2008 as follows:</p> <p>- 88 - 97% compliance for "plan of care reflects interventions to be provided". Although the Quality Improvement (QI) committee audited 373 patient records for this in 2008, they had found that the plan of care was complete and accurate in 341 records. The QI program failed to identify incomplete and inaccurate plans of care as outlined in this report, which resulted in negative outcomes for patients # 1, 3, 4, 22, 23, 27. See G 159</p> <p>- 86 - 97% compliance for "care was provided as ordered on the plan of care". Although the QI committee audited 362 records for this in 2008, they had found that the plan of care was followed in 326 records. The QI committee failed to identify failure to follow the plan of care as outlined in this report. See G 158</p> <p>- 86 - 97% compliance with changes in patient condition being reported to the physician. Although the QI committee audited 259 records for this in 2008, they had found that the physician had been notified of patient changes in 230 records. The QI-committee failed to identify problems with reporting changes in patient condition to the physician as outlined in this report, which resulted in negative outcomes for patients # 1, 3, 20, 22. See G 164.</p> <p>For example, patient #20 was identified as a negative outcome during this report. Specifically, the patient sustained the fall and fractured hip, as a result of the SN failing to coordinate a plan of care with the physician and Physical Therapist in response to a fall the patient had sustained several days earlier. See G 143</p>	G 250	<p>reports and minutes to be provided by the Administrator to the Governing Body three times annually.</p> <p>Completion date: July 27, 2009 Responsible person: DPS</p> <p>Comprehensive record review/audit activities altered to include a Comprehensive Record Review Team. Team members selected have demonstrated ability to perform quality, detailed record review and were provided with orientation/education to record review/audit process and expectations by the PI Coordinator. Team to complete a minimum of 60 reviews a month. PI Coordinator coordinates and oversees comprehensive record review activities on a daily basis.</p> <p>Comprehensive record review tool revised to facilitate reviewer assessment of clinician compliance with:</p> <ul style="list-style-type: none"> <li>Performing a complete comprehensive assessments and reassessments</li> <li>Evaluation visits to be made within 24 hrs of referral unless otherwise ordered or agreed upon</li> <li>Changes in patient condition reported to the physician</li> <li>Development of a complete and accurate Plan of Care to meet the assessed needs of the patient</li> <li>Following of the Plan of Care, agency policy, stds of care and physician orders</li> </ul>		

*Accepted 8/11/09*  
*J. DeManding*



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G 250	<p>Continued From page 88</p> <p>Although the agency audited this patient record, and identified that the SN failed to notify the physician of the fall, the audit did not identify that the SN failed to coordinate a plan with the Physical Therapist and physician prior to discharging the patient from nursing services. The audit failed to identify that the second fall may have been prevented, and the fractured hip may have been avoided. The audit also documented that the audit results were not reviewed with the SN. See G 143</p> <p>The above findings were reviewed with the DPS, ADPS, and QI Nurse on 06/09/09, no additional information was provided.</p> <p>2. The QI committee had identified unacceptable trended results, however, failed to report these results to the PAC committee, and action plans were never developed to correct the problems. For example:</p> <p>-For the 1st quarter of 2009 the comprehensive record audits indicated that physician orders were signed within 30 days only 69% of the time. There is no evidence this was reported to the PAC, or that a plan of action was developed to correct this problem. This survey identified that the agency failed to obtain signed physician orders within 30 days and/or at all, in 9 of 20 patient records reviewed where the patients were on service for greater than 30 days. See G 118</p> <p>- For all 4 quarters in 2008 and the 1st quarter of 2009 the comprehensive audits indicated supervisory Home Health Aide visits were made by the SN every 2 weeks only 47-57% of the time. There is no evidence this was reported to the</p>	G 250	<ul style="list-style-type: none"> <li>• Providing overall Management of patients overall needs</li> <li>• Coordination of care, including approp. communication amongst internal and external care providers, supervisor and physician</li> <li>• Monitoring compliance with all disciplines visit frequency as ordered</li> <li>• Overall patient progress, and the effectiveness and quality of care</li> <li>• Physician orders signed and returned within 30 days</li> </ul> <p>Specific opportunities for improvement to be identified, documented and provided to the approp. Supervising Nurse for 1:1 follow-up with clinicians. Follow-up to be documented and to include alterations to the current plan, as needed, for patients open to the agency, and clinician remediation and discipline as deemed approp. Audit results to be collated and reported to DPS/ADPS weekly for monitoring of response to education provided and enhanced supervision and further intervention as deemed appropriate. Results to be provided monthly (beginning in August) to the PAC for oversight and intervention.</p> <p>Completion date: July 15, 2009 Responsible person: ADPS PI Coordinator</p> <p><i>Accepted 8/11/09</i> <i>H. Demerthe</i></p>		

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G 250

Continued From page 89

PAC, or that a plan of action was developed to correct this problem. the QI committee failed to audit for the quality of HHA supervision being provided by the SNs.

This survey identified that in 4 of 8 records reviewed, where HHA services were provided for greater than 30 days, the SN failed to perform HHA supervisory visits. Patients # 4, 8, 11, 12, 21.

Additionally, the SNs failed to follow the agency's 05/2009 HHA Clinical Supervision Policy. Specifically, the SNs failed to: conduct supervisory visits with the aide present, observe the aide providing care, review the care plan with the aide. As a consequence the SNs failed to identify HHA problems with following the plan of care. See G 158, G 229

3. When the PAC was presented with statistical evidence of problems, the PAC failed to develop an effective action plan to correct the problems. Specifically, the 02/07/09 PAC meeting minutes documented that during the last 3 quarters of 2008, there was only 76 - 46% compliance (with a decreasing trend) for "documentation that wound was measured weekly". The PAC, however, failed to develop an effective action plan to immediately correct the problem.

Specifically, the 02/27/09 PAC meeting minutes documented that although the SNs had been re-educated in wound assessment during the 4th quarter of 2008, the trended audit results for SN compliance/performance had not improved. The PAC failed to review the effectiveness of the plan that was being implemented, and failed to revise the plan to correct the problem.

G 250

Continue focused Plan of Care audit by PI staff on 20% of Start of Care and Recertification records monthly. These audits to be completed after final approval. Process to be overseen by PI Coordinator. Focus of audit to be on clarity of orders, compliance with agency stds of care, and compliance with record selection. will focus on wounds, diabetes management and orders as relates to changes in patient condition.

Completion date: June 3, 2009  
Responsible person: ADPS  
PI Coordinator  
PI Staff

Development of an audit team comprised of RN, LPN and PT staff to perform focused audits on specific patient populations trended to have had negative outcomes during NYSDOH survey. Auditors educated to audit function and weekly meetings held to discuss results and minimize variances in audit activities. Meetings are minuted.

Daily wound visit audits conducted on all patients with identified open wounds including surgical wound, stasis ulcer, and decubitus ulcer to assess compliance with wound assessment, including, but not limited to:

- Wound assessment and measurement
- Completeness of wound care orders
- Provision of ordered wound care
- Approp. follow-up and communication of changes in condition to physician and Supervising Nurse

*Accepted 8/11/09  
H. Reardon*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/27/2009
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NAME OF PROVIDER OR SUPPLIER

ST JOSEPHS HOSP HEALTH CENTER CHHA

STREET ADDRESS, CITY, STATE, ZIP CODE

7246 JANUS PARK DRIVE  
LIVERPOOL, NY 13088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 250	<p>Continued From page 90</p> <p>The agency ADPS and QI Nurse developed a plan for the 1st quarter of 2009 which included increased "in home" supervision of the SNs, however, there is no evidence the PAC reviewed the plan, and failed to identify that the plan was incomplete and failed to specify: if all of the SNs would receive supervisory visits, who would be responsible for making the visits, who would ensure the plan was implemented, a date that the initial supervisory home visits would be completed by.</p> <p>On 07/09/09 the surveyor reviewed the trended QI results for the supervisory visits with the DPS. The surveyor questioned why only 26 SNs had received supervisory visits during the first quarter of 2009. The DPS stated that the SNs received the supervisory visits only as they were due for their yearly evaluations. The CMS 1572 form, completed by the agency during this survey, documented that the agency had 83 registered nurses.</p> <p>The PAC failed to evaluate if this corrective action plan would be adequate to correct the problem, and this survey identified that in 11 of 11 (100%) of patient records where wounds were identified, the SN failed to measure the wounds weekly. Patients # 1, 2, 4, 5, 8, 10, 13, 14, 18, 19, 27. This resulted in a negative outcome for patient #1. See G 171</p> <p>4. The governing body failed to ensure the agency's delivery of quality care. Specifically:</p> <p>- Although the Governing Body discussed the agency's QI results and action plans for correction, at the 03/27/09 and 05/29/09</p>	G 250	<ul style="list-style-type: none"> <li>Positive and negative performance feedback provided to clinicians and Supervising Nurses for approp. follow-up.</li> </ul> <p>Completion date: June 3, 2009 to June 28, 2009 Responsible person: DPS</p> <p>Per visit wound audit upgraded to weekly per patient wound audit to facilitate auditor assessment of compliance with wound assessment and wound progress over time. Audit items as above.</p> <p>Completion date: June 28, 2009 Responsible person: PI Coordinator</p> <p>Wound audit tool updated and audit staff re-educated to audit function with new tool. New audit tool to move audit from visit compliance to overall quality of care provided and management of the patient's wound and corresponding needs throughout the episode of care in accordance with agency policy, procedure and stds in the provision of care to patients with wounds.</p> <p>Completion date: August 6, 2009 Responsible person: ADPS</p> <p><i>Accepted 8/11/09</i> <i>H. DeMartino</i></p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  ST JOSEPHS HOSP HEALTH CENTER CHHA	STREET ADDRESS, CITY, STATE, ZIP CODE 7246 JANUS PARK DRIVE LIVERPOOL, NY 13088
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G 250	<p>Continued From page 91</p> <p>Executive Committee meetings, the QI and PAC committees failed to identify all of the agency's problems and communicate them to the Governing Body, as identified above.</p> <p>- Although the Governing Body met on 07/25/08, 12/05/08, and 01/30/09, they failed to discuss any QI results prior to the 03/27/09 and 05/29/09 meetings.</p> <p>- The Governing Body failed to ensure that the PAC conducted an Annual Agency Evaluation. See G 243</p> <p>The above information was reviewed with the DPS, ADPS, and Quality Improvement Nurse. No additional information was provided.</p>	G 250	<p>Weekly per patient audit conducted for all patients identified at nutritional risk thru clinician/Supervising Nurse report, or documented change in appetite and/or decreased intake and/or weight change, and all patients receiving enteral or parenteral nutrition. Audit to focus on overall quality of care provided and management of the patient's nutrition through the episode of care in accordance with agency policy, procedure and stds in the provision of care to patients with nutritional risk. PI Coordinator to oversee audit process.</p> <p>Completion date: August 7, 2009 Responsible person: ADPS</p> <p>Weekly per patient audit conducted on all patients identified with or having documented type I, Type II diabetes or hypo/hyper/hypoglycemia. Audit to focus on overall quality of care provided and management of the patient's diabetes episode of care in accordance with agency policy, procedure and stds in the provision of care to the diabetic patient population. PI Coordinator to oversee audit process.</p> <p>Completion date: July 27, 2009 Responsible person: ADPS</p> <p>All audit results to be trended by PI staff and reported weekly to DPS/ADPS for monitoring of response to enhanced audit with real-time follow-up, education provided, enhanced supervision, and further intervention as deemed appropriate. Action plans to be developed and implemented to address identified deficient trends. Results and action plans to be presented to the PAC monthly (beginning in August) for oversight, intervention, and approval. The Administrator to present audit trends and action plans to the Board of Directors Executive Committee quarterly, and the Governing Body three times a year.</p>	

*Accepted 8/1/09 [Signature]*

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NAME OF PROVIDER OR SUPPLIER  GENTIVA HEALTH SERVICES LIVERPOOL			STREET ADDRESS, CITY, STATE, ZIP CODE 200 ELWOOD DAVIS ROAD LIVERPOOL, NY 13088		
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G 000	<p>INITIAL COMMENTS</p> <p>The following statement of deficiencies is the result of a recertification survey and an onsite investigation of 4 complaints: NY00066934, NY00066961, NY00066182, NY00069327.</p> <p>A post certification survey of the agency was commenced on 1/13/09. The post certification survey was initiated as a follow up to the recertification survey completed on August 13, 2008, event SG7Q11.</p> <p>On January 21, 2009, it was determined that none of the citations identified on the August 13, 2008 survey had been corrected, and additional deficiencies were identified. The survey was converted to an extended survey, which consisted of a review of a total of 41 patient records, including 25 observational home visits. Clinical record reviews and observational home visits were conducted at the parent office as well as the two branch offices, located in Oswego and Auburn, New York.</p> <p>Deficient practices were identified at condition level non-compliance in the following 5 Conditions of Participation: Organization, Services and Administration; Group of Professional Personnel; Acceptance of Patients, Plan of Care, and Medical Supervision; Skilled Nursing Services; and Evaluation of the Agency's Program. Negative outcomes were identified for a total of seven patients: #1, 2, 6, 26, 27, 30, 37, and the potential for negative outcomes for the agency's entire patient population.</p> <p>Interviews were conducted with the Administrator (hired 10/30/08 and reassigned on 02/04/09), acting Administrator, Director of Clinical</p>	G 000	<p><i>POC #3</i></p> <p><i>The following patients are discharged:</i></p> <p><i>#1 #2 #3 #4 #5</i></p> <p><i>#6 #7 #8 #9 #10 #11</i></p> <p><i>#12 #14 #15 #16</i></p> <p><i>#17 #18 #19 #20</i></p> <p><i>#23 #24 #26 #27</i></p> <p><i>#28 #29 #30 #31 #32</i></p> <p><i>#33 #34 #35 #36</i></p> <p><i>#37 #38 #39 #40</i></p> <p><i>#21 order for eye gtt obtained</i></p> <p><i>#13 in hospital presently</i></p> <p><i>#22 AN put on action plan and documentation review</i></p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Sharon DeSavero RN BSN AD 5/14/09

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution has taken appropriate safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER

GENTIVA HEALTH SERVICES LIVERPOOL

STREET ADDRESS, CITY, STATE, ZIP CODE

200 ELWOOD DAVIS ROAD  
LIVERPOOL, NY 13088

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Sharon DeGavero RUBEN AD 5/8/09

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 000	Continued From page 1  Management, acting Director of Clinical Management, Director of Performance Improvement, Supervising Nurses and staff members throughout the survey.  The following agency records were requested and reviewed during the extended survey: administrative and clinical policies and procedures, Professional Advisory Committee meeting minutes for 2007 and 2008, Governing Body meeting minutes for 2008, the agency's Annual Program Evaluation for 2007, Quality Improvement Program, the agency's Adverse Event Outcome Report for the period 8/08 to 10/08, Emergency Preparedness Plan, on-call log, and complaint log for the parent and each branch office.  Additionally, 33 personnel records were reviewed for professional and para-professional staff.  Throughout the survey, each clinical record chosen as part of the sample was reviewed with the acting Administrator, acting Director of Clinical Management and Supervising Nurses.	G 000		
G 118	484.12(a) COMPLIANCE WITH FED, STATE, LOCAL LAWS  The HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations. If State or applicable local law provides for the licensure of HHAs, an agency not subject to licensure is approved by the licensing authority as meeting the standards established for licensure.  This STANDARD is not met as evidenced by: Evidence is lacking that the agency is in	G 118 <i>5/15/09 acceptable</i> <i>Paula fuller nurse HSC</i>	G118 484.12(a) Compliance with Federal, State and Local laws and Regulations  The two registered nurses N and Z have obtained a written document/clearance from their physician stating that they are not actively infected with TB. Date: N has the documentation 4/21/09 and Z 4/01/09. This documentation has been placed in their personnel files. In addition a position was added to the branches to perform all personnel activities and ensure compliance.	<i>4/21/09</i> <i>4/01/09</i>

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G 118	<p>Continued From page 2</p> <p>compliance with all applicable Federal, State, and local laws and regulations. Specifically, the agency failed to ensure that Title 10 of NYCRR Part 763.13 (4) are implemented as follows:</p> <p>Based on review of 2 of 2 registered nurses with a history of testing positive during a ppd skin test for tuberculosis, and interviews with the acting Administrator, evidence is lacking that appropriate clinical follow-up was complete. Employees N, Z</p> <p>Failure to conduct appropriate clinical follow-up to positive tuberculosis findings has the potential for exposure of patients and employees to tuberculosis.</p> <p>Specifically:</p> <p>Employee N had a history of a positive PPD in 1978. Evidence of a chest x-ray on 11/6/06 showed negative results. Another chest x-ray was completed 4/21/08, stating "negative PA chest." Evidence was lacking that the employee's primary physician reviewed the x-ray results and either made recommendations for follow-up, if necessary, or cleared the employee to work.</p> <p>Employee Z had a chest x-ray completed on 4/1/08 due to history of a cough, with stated results of "no acute disease of the chest." Evidence was lacking that the employee's primary physician reviewed the x-ray results and either made recommendations for follow-up, if necessary, or cleared the employee to work.</p> <p>This was reviewed with the acting Administrator on 02/09/09. No further evidence was provided.</p>	G 118	<p>10 Personnel Files will be audited by the RC 2 (records coordinator) each quarter to ensure required documentation is present in the files. A summary of this audit will be provided to administrator and this audit will be incorporated in the PAC meetings. This will begin May 11, 2009.</p> <p>In addition the RC2 will run employee compliance report that has all employees listed and attend the morning meetings biweekly to inform the MCP staff of: Status of CPR/TB renewals License renewals Performance evaluations Supervised visits required. This will be monitored by the employee compliance report and those areas not completed by the due date, the RC2 will complete a report for the Administrator, monthly as the process will be proactively identifying compliance requirements a month previous to the expiration. The Administrator/DPS will follow-up with the MCP.</p> <p>The administrator is responsible for compliance with this standard. Lack of compliance will lead to disciplinary activities. Disciplinary actions will be documented and placed in their personnel files.</p>		<p>5/27/09 or on going</p> <p>5/27/09 or on going</p>
G 122	484.14 ORGANIZATION, SERVICES & ADMINISTRATION	G 122	<p><i>a acceptable</i> <i>Raul Williams RN</i> <i>5/15/09</i></p>		



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NAME OF PROVIDER OR SUPPLIER  <b>GENTIVA HEALTH SERVICES LIVERPOOL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 ELWOOD DAVIS ROAD LIVERPOOL, NY 13088</b>		
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G 122	Continued From page 3  This CONDITION is not met as evidenced by: o Failure to identify patients who have the potential to develop negative outcomes and failure to implement systems and interventions designated to the prevention of those negative outcomes. G140,143,168  o Failure of the governing body to assume responsibility for the overall management of the agency. G128  o Failure of the governing body to ensure that individuals appointed to the position of Administrator receive adequate orientation and training and that clear and consistent lines of authority within the agency, from the administrator down to the delivery of patient care are established. G 128, G133  o Failure to ensure that all staff hired at various levels within the agency are qualified for the assigned positions and that they receive sufficient orientation, training, and supervision to perform their job responsibilities G128, G140  o Failure of the governing body to ensure that the individual appointed to the position responsible for supervision of nursing and therapy staff (Director of Clinical Management) possesses the necessary qualifications for the position and that the employee received adequate orientation, training and supervision G138  o Failure to ensure administrative and supervisory functions are performed effectively	G 122	G122 484.14 Organization, Services and Administration Condition  Failure to identify patients who have the potential to develop negative outcomes and failure to implement systems and interventions designated to the prevention of those negative outcomes. G140, 143. 168  With respect to G140 supervision of a professional nurse, G143 coordination of care to meet the objectives of the plan of treatment and G168 skilled nursing services following systemic issues have been addressed and corrected to improve accountability of the MCP staff and clinical staff: 1.) The implementation of area teams in each branch so that it is clear to the MCP and to their staff who is the MCP they report to and to the MCP who they supervise 2.) To improve supervision a team was added to the Liverpool, Oswego and Auburn branch, so that each MCP has a smaller group of clinicians to supervise/manage and a smaller patient census per team. 3.) Reduced case manager caseloads to promote quality in patient care and documentation. This was done by hiring additional RN staff. The RN staff will be case managing between 25-30 patients. 4.) 100% review by the MCP of all SOC assessments and the POT.		5/6/09 5/6/09 5/6/09 4 on going

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G 122	<p>Continued From page 4</p> <p>and that agency policies and procedures are appropriate and implemented consistently G133,140</p> <ul style="list-style-type: none"> <li>o Failure to develop and implement a system which ensures that changes in patient condition are promptly identified and reported to the physician, and that priority needs are addressed, both of which are necessary to the prevention of negative patient outcomes.</li> <li>o Failure to ensure effective communication and coordination between all disciplines including supervisory staff as outlined in agency policy. G143,144</li> <li>o Failure to ensure internal quality assurance/improvement audits are of sufficient scope to identify quality of care issues, that results are trended, and that adequate plans are being developed and revised for the resolution of identified problems. G250</li> </ul> <p>The cumulative effect of these systemic problems resulted in the home care agency's failure to ensure the provision of quality health care. Additionally, this failure to provide oversight resulted in negative outcomes for seven patients: #1, 2, 6, 26, 27, 30, 37 and potential negative outcomes for the agency's entire patient population.</p> <p>On December 26, 2006 a recertification survey was completed and determined 4 Conditions were not in compliance. Although all 4 conditions were back in compliance during re-visits completed on 03/19/07 and 08/13/08, the agency failed to maintain compliance in the following areas: supervision of professional and</p>	G 122	<p>5.) SOC case conference within the first week of care to review the POC is appropriate to meet the patient's needs</p> <p>6.) The case conference process is as follows: It will be held weekly, patients will be selected by that have just been open to services (SOC); resumption of care, recertification and/or discharge; if the patients condition is unstable, fragile or requires frequent changes in the POC or multidisciplinary. Wound care conferences will occur per policy. Case conferences will consist of a review of patient care and coordination including but not limited to services provided; progress within the care plan; progress towards goals should the patient be discharged or recertified. The medical record will be utilized to facilitate the case conference.</p> <p>7.) The MCP will ensure follow-up visits are assigned as needed with changes in patient condition The MCP will ensure the RN/PT assess the patient and that the RN/PT, LPN/PTA practice within their scope of practice (observe and report).</p>	<p>5/21/09 ongoing</p> <p>5/21/09</p>	

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G 122	Continued From page 5 paraprofessional staff; supervision of patient care; coordination of care; identification of changes in patient condition; skilled nursing care; and evaluation of the agency's program.	G 122	8.) Due to accountability/performance issues the scheduling staff has been replaced (with the exception of two) to assist in the coordination of patient visits within the teams and case managers. The RN identifies the LPN visits and provides to the scheduler a schedule of RN and LPN visits at the SOC for that episode of care. PT identifies their visits and the visits the PTA will be making. The LPN/PTA will communicate with the RN/PT on a daily basis. This will be documented on the bottom of the visit note.	04/15/09
G 128	484.14(b) GOVERNING BODY  A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.  This STANDARD is not met as evidenced by: Based on a review of 41 clinical records, 25 observational home visits, Governing Body meeting minutes dated October 21, 2008, Professional Advisory Meeting Minutes dated September 23, 2008 and December 2, 2008, the Annual Program Evaluation dated June 3, 2008 for the year 2007, and interviews with the agency Administrator, the Director of Performance Improvement, and staff at all levels within the agency, evidence is lacking in 39 clinical records and 25 observational home visits that the Governing Body effectively oversees the operation and management of the agency. Patients # 1-11, 14-41.  Failure of the Governing Body to provide adequate oversight and direction of the agency resulted in negative outcomes for seven patients: # 1, 2, 6, 26, 27, 30, 37, multiple repeat standard level deficiencies and multiple repeat condition level deficiencies as outlined in the body of this report.  Specifically, evidence is lacking that the following Governing Body responsibilities are being performed:	G 128	9.) The Governing Body will monitor the implementation of the Plan of Correction through weekly and then monthly calls with the AVP of Regulatory Affairs, the RVP and the VP of Clinical Operations. The status of compliance will be measured through chart audit results shared with the members of the call along with orientation and personnel file audits. The monitoring and current status of case manager case loads will also be presented for input and recommendations.  10.) As issues are identified field supervision will occur by the MCP/designee with the clinicians. These include but are not limited to: with lack of quality documentation and care issues; patients who have verbalized a compliant with services; New staff within 60 -90 days and existing staff will have their yearly supervisory visits per policy.	04/21/09

89Z  
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G 122	Continued From page 5 paraprofessional staff; supervision of patient care; coordination of care; identification of changes in patient condition; skilled nursing care; and evaluation of the agency's program.	G 122	11.) The Administrator/DPS will meet with the MCP staff bi-weekly and hold MCP conference calls weekly in-between. These meetings will address care and documentation issues; staffing needs;	6/2
G 128	484.14(b) GOVERNING BODY  A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.  This STANDARD is not met as evidenced by: Based on a review of 41 clinical records, 25 observational home visits, Governing Body meeting minutes dated October 21, 2008, Professional Advisory Meeting Minutes dated September 23, 2008 and December 2, 2008, the Annual Program Evaluation dated June 3, 2008, for the year 2007, and interviews with the agency Administrator, the Director of Performance Improvement, and staff at all levels within the agency, evidence is lacking in 39 clinical records and 25 observational home visits that the Governing Body effectively oversees the operation and management of the agency. Patients # 1-11, 14-41.  Failure of the Governing Body to provide adequate oversight and direction of the agency resulted in negative outcomes for seven patients: # 1, 2, 6, 26, 27, 30, 37, multiple repeat standard level deficiencies and multiple repeat condition level deficiencies as outlined in the body of this report.  Specifically, evidence is lacking that the following Governing Body responsibilities are being performed:	G 128	these meetings in addition to the morning meetings. These meetings will be documented. 12.) Revamped orientation program to ensure that new clinicians have the time to adapt to homecare before given a full assignment. They will gradually increase their case load based on their ability to complete quality documentation and care. Their skills are verified by the educator and their preceptor in the field. The MCP will meet with the orientee weekly once on her team. Revised PI program and PAC to include the following measures: a.) Clinical Record Review results b.) New orientation chart audits c.) Personnel file audits d.) Quarterly policy reviews e.) RN case management case load reports f.) Results of the monthly team audits g.) Adverse events h.) Trends of complaints, incidents and infections i.) Inclusion of the AVP of Regulatory Affairs as a member of the PAC committee. (a member of the Governing Body) Governing Body weekly calls with the VP of Clinical Operations; the AVP of Regulatory Affairs; the RVP of operations will be held with the Administrator until the conditions are lifted and then become monthly. The members of the calls will be sent Chart audit results; orientation chart audit results and case manager case load reports.	5/27/09 going 5/19/09 going 4/21/09 going

#2  
page  
4

The Administrator is responsible for all of the  
above outcomes.

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G 128	<p>Continued From page 6</p> <p>o Exercising its ability for the overall management and supervision of the agency. Evidence is lacking that the Governing Body understood it's responsibility to provide oversight and direction specific to the agency. Specifically, the Governing Body minutes dated October 21, 2008 for a meeting at the corporate level lack a specific reference to the CHHA located in Liverpool, New York and and its two branches located in Oswego, New York and Auburn, New York. The minutes contain a general statement: "No substantive recommendations had been made for Governing Body consideration. Where noted, office administrators and staff will respond to recommendations within their respective markets".</p> <p>o Ensuring that supervision of all patient care is provided and readily available. Specifically, that supervisors are ensuring that: case coordination and case management are being performed; patients receive the necessary services based on a professional assessment of the patient's needs; plans of care are completed and followed; changes in patient condition are identified and reported to the physician; nursing assessments are complete and accurate; and nurses are qualified, trained, and supervised. G140, 143, 144, 158, 159, 171, 172</p> <p>Evidence is lacking that the administrator was given the authority to provide oversight of the entire agency operations and the Director of Clinical Management lacked the clinical experience to oversee the clinical operations of the agency.</p> <p>Specifically, on 02/09/09 the surveyor interviewed the individual who was functioning as the</p>	G 128	<p>G Tag #128 484.14(b) Governing Body assumes full legal authority and responsibility for the operations of the agency.</p> <p>Governing Body Calls: the AVP of Regulatory Affairs and the VP of Clinical Operations along with the RVP of Operations and the Administrator are conducting weekly conference calls. The calls will review progress with the plan of correction. The calls will review the plan of correction. The governing body will assist in providing any support needed to the ensure quality documentation, care and services for our patients. The calls will begin on April 21, 2009. Governing body calls will continue weekly until the conditions are lifted. They will then become monthly through 2009.</p> <p>Monthly chart audit results, orientation audits and case manager case load status will be shared with the governing body calls for their input and recommendations. The governing body will review and approve action plans. The Governing Body calls are documented by the Governing Body and sent to the Administrator.</p> <p>All aspects/staff within the three branches report through a MCP/designee to the Administrator/DPS who has the responsibility to direct and organize the branches' on going functions. The DPS will report directly to the Administrator. The administrator is a liaison to the governing body and reports through weekly/monthly conference calls.</p>	<p>5/15/09 acceptable Paula Williams RAHase</p> <p>5/21/09 5/27/09</p>

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G 128	<p>Continued From page 7</p> <p>Administrator from October 30, 2008 until February 4, 2009. She stated that all clinical services were being supervised by a Corporate Vice President, and that she had no role for clinical oversight of the agency. The Corporate Vice President was located in Binghamton, NY and had oversight of multiple agencies within New York State. The Administrator stated that until December 18, 2008 she did not supervise the Director of Clinical Management (DCM), but instead, the DCM was supervised by a corporate Vice President. The Administrator further stated that the Director of Clinical Management implemented several changes, autonomously, and failed to follow established agency policy; and that the Administrator had no authority over the DCM. This reporting structure was changed on December 18, 2008, at which time the DCM reported to the Administrator. Furthermore, the surveyor determined through a review of the resume for the Director of Clinical Services, that she lacked the required experience for the position. The corporation terminated the DCM on January 19, 2009. The surveyor was notified in writing on February 9, 2009 that the agency's Director of Performance Improvement was reassigned to the position of DCM, designated in an acting capacity because she, too, lacked the qualifications for the position.</p> <p>The Governing Body also failed to ensure continuity with respect to administration of the agency. Specifically, four different Administrators and three different Directors of Clinical Management were appointed to these positions since August 13, 2008, the date of the prior New York State Department of Health recertification survey. On February 9, 2009, the agency provided written notification to the New York State</p>	G 128	<p>The AVP of Regulatory Affairs will become of member of the PAC committee. He will join either via conference call or in person. He will receive a copy of the PAC meeting minutes. <i>He is the governing body representative</i></p> <p>Any Governing Body recommendations will be integrated into the action plan developed with the PAC.</p> <p>Hiring for management roles (DCM, MCP, and Administrator) will follow the company and state guidelines and experience /education requirements. It will be the AVP/designee responsibility to ensure only qualified professionals are hired. This will be evident by the AVP signature within the interview process.</p>	5/19/09	

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G 128	Continued From page 8 Department of Health that a new Administrator, who is the Regional Director of Clinical Operations, was reassigned to the CHHA. The Administrator from October 30, 2008 until February 4, 2009 was reassigned to the position of Business Manager.  o Ensuring internal agency audits are of sufficient scope to identify quality of care issues and deficient practices, and that resolutions are developed and implemented. G250  o Ensuring that the agency's Professional Advisory Committee reviews and revises agency policies and procedures, as needed and at least annually. G153, 248  o Ensuring that the agency is consistently functioning in full compliance with all applicable rules and regulations as outlined in this report.	G 128			
G 132	484.14(b) GOVERNING BODY  The governing body oversees the management and fiscal affairs of the agency.  This STANDARD is not met as evidenced by: See G128	G 132			
G 133	484.14(c) ADMINISTRATOR  The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.  This STANDARD is not met as evidenced by:	G 133			

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G 133	<p>Continued From page 9</p> <p>Based on a review of 41 clinical records, and interviews with the present and previous agency Administrators, interviews with the previous and acting Director of Clinical Management, interviews with agency staff, review of personnel records and agency policies and procedures, and review of Professional Advisory Committee and Governing Body minutes, evidence is lacking in 39 records that the Administrator effectively oversees the operation and management of the agency.</p> <p>Patients #1-11, 14-41.</p> <p>Failure of the agency Administrator to provide adequate oversight and direction of the agency resulted in negative patient outcomes for seven patients: #1, 2, 6, 26, 27, 30, 37, multiple repeat standard and condition level deficiencies, and creates the potential for agency wide negative patient outcomes.</p> <p>Specifically, evidence is lacking the following responsibilities of the Administrator are being performed:</p> <ul style="list-style-type: none"> <li>o Ensuring the Professional Advisory Committee annually reviews the agency's administrative and clinical policies G153</li> <li>o Ensuring an effective plan is implemented to maintain compliance with 42 CFR 484. Specifically, during a recertification survey dated 12/28/06, the agency was found out of compliance with the following four Conditions of Participation: Organization, Services, and Administration; Acceptance of Patients, Plan of Care, and Medical Supervision; Skilled Nursing Services; and Evaluation of the Agency's Program. Although the agency was able to</li> </ul>	G 133	<p><i>Governing Body calls</i></p> <p>Implementation of the Plan of Correction will be monitored through weekly and then monthly calls with the AVP of Regulatory Affairs, the RVP and the VP of Clinical Operations. The status of compliance will be measured through chart audit results shared with the members of the call along with orientation and personnel file audits. The monitoring and current status of case manager case loads will <sup>also</sup> be presented for input and recommendations.</p> <p>Revised PI program and PAC to include the following measures:</p> <ul style="list-style-type: none"> <li>a.) Clinical Record Review results</li> <li>b.) New orientation chart audits</li> <li>c.) Personnel file audits</li> <li>d.) Quarterly policy reviews</li> <li>e.) RN case management case load reports</li> <li>f.) Results of the monthly team audits</li> <li>g.) Adverse events</li> <li>h.) Trends of complaints, incidents and infections</li> <li>i.) Inclusion of the AVP of Regulatory Affairs as a member of the PAC committee.</li> </ul> <p>The administrator is responsible for compliance with this standard. Lack of compliance will lead to disciplinary activities.</p>	<p>5/18/09 + on going</p>



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G 133	<p>Continued From page 9</p> <p>Based on a review of 41 clinical records, and interviews with the present and previous agency Administrators, interviews with the previous and acting Director of Clinical Management, interviews with agency staff, review of personnel records and agency policies and procedures, and review of Professional Advisory Committee and Governing Body minutes, evidence is lacking in 39 records that the Administrator effectively oversees the operation and management of the agency.</p> <p>Patients #1-11, 14-41.</p> <p>Failure of the agency Administrator to provide adequate oversight and direction of the agency resulted in negative patient outcomes for seven patients: #1, 2, 6, 26, 27, 30, 37, multiple repeat standard and condition level deficiencies, and creates the potential for agency wide negative patient outcomes.</p> <p>Specifically, evidence is lacking the following responsibilities of the Administrator are being performed:</p> <ul style="list-style-type: none"> <li>o Ensuring the Professional Advisory Committee annually reviews the agency's administrative and clinical policies G153</li> <li>o Ensuring an effective plan is implemented to maintain compliance with 42 CFR 484.</li> </ul> <p>Specifically, during a recertification survey dated 12/28/06, the agency was found out of compliance with the following four Conditions of Participation: Organization, Services, and Administration; Acceptance of Patients, Plan of Care, and Medical Supervision; Skilled Nursing Services; and Evaluation of the Agency's Program. Although the agency was able to</p>	G 133			

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5/15/09 acceptable Paul Williams RN

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G 133	<p>Continued From page 10</p> <p>demonstrate correction of the four Condition level deficiencies on 3/19/07, repeat standard level deficiencies were cited on 8/13/08. Multiple repeat standard and condition level deficiencies are cited within the body of this report. The same four Conditions cited on 12/28/06 recertification survey are out of compliance which demonstrates the failure to maintain compliance. Evidence is lacking that the Administrator ensured that the agency continued to implement the plans of correction submitted to the New York State Department of Health in response to these respective surveys.</p> <p>o Ensuring internal quality assurance audits are provided to the governing body and that an effective plan is developed to resolve areas in need of improvement. G250</p> <p>o Ensuring the provision of adequate supervision of patient care and skilled nursing staff. Specifically, that supervisors are ensuring that: case coordination is being performed; plans of care are complete and being implemented; changes in patient condition are being reported to the physician; nursing assessments are complete and accurate; and nurses are oriented, trained and evaluated as clinically competent. G134</p> <p>On February 9, 2009, the surveyor interviewed the employee who was functioning as the Administrator from 10/30/08 until 02/04/09. The Administrator stated that she did not supervise the Director of Clinical Management (DCM) until 12/18/08. The DCM reported to a corporate Vice President during this time period. The Administrator stated that until 12/18/08, she had no role in the clinical oversight of the agency.</p>	G 133	<p>1.) The implementation of area teams in each branch so that it is clear to the MCP and to their staff who is the MCP they report to and to the MCP who they supervise</p> <p>2.) To improve supervision a team was added to the Liverpool, Oswego and Auburn branch, so that each MCP has a smaller group of clinicians to supervise/manage and a smaller patient census per team. As team census grows over 125-150 a QA coordinator will be added to the team.</p> <p>3.) Reduced case manager caseloads to promote quality in patient care and documentation. This was done by hiring additional RN staff. The RN staff will be case managing between 25-30 patients.</p> <p>4.) 100% review by the MCP of all SOC assessments and the POT to ensure accuracy and that the POT is appropriate based on the assessment. This will be documented on the SOC tool.</p> <p>5.) SOC case conference within the first week of care to review the POC is appropriate to meet the patient's needs</p> <p>6.) The case conference process is as follows: It will be held weekly, patients will be selected by that have just been open to services (SOC); resumption of care, recertification and/or discharge; if the patients condition is unstable, fragile or requires frequent changes in the POC or multidisciplinary. Wound care conferences will occur per policy.</p> <p>Case conferences will consist of a review of patient care and coordination including but not limited to services provided; progress within the care plan; progress towards goals should the patient be discharged or recertified. The medical record will be utilized to facilitate the case conference.</p>		<p>5/27/09</p> <p>5/27/09</p> <p>5/27/09</p> <p>5/27/09</p> <p>5/27/09</p>

5/27/09 acceptable  
Paula Williamson-Hase

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 133	Continued From page 11 o Ensuring that safe discharge plans are being developed and approved by the physician, prior to patient discharge.	G 133	The Administrator/DPS will meet with the MCP staff bi-weekly and hold MCP conference calls weekly in-between. These meetings will address care and documentation issues; staffing needs; educational needs of the team and audit and employee compliance outcomes. Complaints and Incidents will be reviewed at these meetings in addition to the morning meetings.	5/27/09 + on going	
G 134	484.14(c) ADMINISTRATOR  The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.  This STANDARD is not met as evidenced by: Based on review of 24 personnel records of skilled nurses (RNs and LPNs), review of the agency's Orientation policy, and interviews with 6 skilled nurses, the Area Staff Development Specialist and acting Administrator, evidence is lacking in 11 records that the administrator has ensured that staff complete the agency orientation process. (Employees B, D, F, G, J, K, N, X, Y, BB, DD)  In addition, 7 of 24 skilled nursing personnel records lacked a complete assessment of skills prior to the provision of patient care. (Employees A, C, J, AA, EE, FF, GG)  Failure to provide a complete orientation process and adequately assess nursing skills prior to patient contact has the potential for negative patient outcomes.  Specifically, the lack of orientation is as follows:  - Personnel records for 3 registered nurses lacked any evidence of orientation. Employees Y, BB and DD.	G 134	Orientation has been evaluated and the changes to this process are as follows: Orientation has three phases: didactic instructions/ revisits with a preceptor, OASIS training and completion of OASIS assessments with their preceptor, case management and MCP managed case loads to be specific to the clinicians ability to manage patients.  Effectiveness of orientation will be measured through a chart audit of 5 records once they begin case management. The DCM/designee will be responsible to perform these audits. The DCM will work with the MCP to ensure continued mentoring or a decision will be made as the clinician's ability to perform and document homecare services.  The MCP is the over-all "preceptor" and will review the documentation and meet with the clinicians weekly. <i>The MCP therefore is responsible for the completion of orientation.</i>	5/27/09 + on going	

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G 134	<p>Continued From page 12</p> <p>- Evidence of any orientation was lacking for the Director of Clinical Management (hired 08/13/08 to 01/19/09). Specifically, the personnel record only contained documentation of meeting other employees throughout the organization. There was no documentation of orientation to her role as Director of Clinical Management. Employee M</p> <p>- In 3 of 6 personnel records for employees assigned as Managers of Clinical Practice (Supervising Nurses), evidence is lacking of a complete orientation. Specifically, there is no evidence that each employee was oriented to their role as Managers of Clinical Practice. Employees G, J, K.</p> <p>In 4 of 10 personnel records reviewed for registered nurses, evidence is lacking that the orientation was completed and documented. Employees B, D, N, and X.</p> <p>In 6 of 16 personnel records reviewed for RNs and LPNs, evidence is lacking that the following skills competencies were assessed prior to patient assignment:</p> <p>- Employee A (an LPN)- lacked competency in Gastrointestinal/Nutrition and Urinary Care and Pediatric Procedures these sections were left blank.</p> <p>- Employee FF (an LPN) - lacked competency in Gastrointestinal/Nutrition, Endocrine, Urinary Care, Pediatric Procedures these sections were left blank.</p> <p>- Employee GG, (an LPN) lacked competency in Dressing and Wound Care, Cardiopulmonary Care; Gastrointestinal/Nutrition; Endocrine;</p>	G 134	<p>4.) A clinical skills fair is being scheduled will take place by May 22, 2009. The fair will be provided by the educator. New skills demonstrated will be signed and updated on the skills checklist. The skills checklist will be kept in a binder with the MCP so that as patient needs are identified the MCP can match the nurse with those skills to the patient.</p> <p>5.) Outcomes of the orientation chart audits performed by the MCP/Designee will be reviewed monthly by the Administrator/DPS and discussed with the educator and also at the weekly MCP meetings. The results will be presented at the quarterly PAC meetings for additional recommendation for improvement as necessary.</p> <p>The following employees have had the following corrected:</p> <p>Employee Y and BB have resigned Employee DD: the educator She Will need to recreate her orientation materials. To be completed by May 15, 2009.</p> <p>The DCM was termed. Employee K completed checklist is in the file Employee D checklist completed Employee G covering DCM role presently, is not remaining in the role. Employee B checklist was completed, just not in folder, present currently. Employee B check list in folder from 2006 Employee N checklist was in file Employee X resigned</p>	<p>5/27/09</p> <p>5/27/09</p> <p>5/15/09</p>

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NAME OF PROVIDER OR SUPPLIER

**GENTIVA HEALTH SERVICES LIVERPOOL**

STREET ADDRESS, CITY, STATE, ZIP CODE

**200 ELWOOD DAVIS ROAD  
LIVERPOOL, NY 13088**

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G 134	<p>Continued From page 13</p> <p>Medication Administration; Pain Management; Urinary Care; and Fall Prevention Management, these sections were left blank. Additionally, the competency evaluation for fingerstick PT/INR and glucometer was completed an LPN.</p> <ul style="list-style-type: none"> <li>- Employee AA, (an RN) lacked competency in Gastrointestinal/Nutrition and Urinary Care these sections were left blank.</li> <li>- Employee EE, (an RN), lacked competency in Gastrointestinal/Nutrition and Urinary Care, and Infusion Therapy these sections were left blank.</li> <li>- Employee C, (an RN), lacked competency in Gastrointestinal/Nutrition and Urinary care. Infusion Therapy and Pediatric Procedures, these sections were left blank.</li> </ul> <p>Additionally, evidence is lacking that the administrator ensures that annual performance evaluations are complete.</p> <p>Based on review of 16 personnel records of professional and para-professional staff who have been employed for 12 or more months, and interviews with the Area Staff Development Specialist and acting Administrator, evidence is lacking in 6 records of an annual performance assessment. (Employees D, E, P, Q, R, T)</p> <p>Failure to conduct an annual assessment of each employees' performance and effectiveness may lead to unmet patient needs and/or negative patient outcomes.</p> <p>Specifically:</p> <p>Employee D is a Clinical Account Executive</p>	G 134	<p>Employee A nutritional assessment was signed off 8/26/08 No other competencies were required.</p> <p>Employee FF Nutritional assessment was signed off 8/26/08. Intermittent catheterizations signed off 8/26/08.</p> <p>Employee GG skills observed by ASDS on supervisory visit 1/19/09. Skills list updated.</p> <p>Employee AA no completions were required.</p> <p>Employee EE No completions were required, does not perform infusion.</p> <p>Employee C No competencies were required, does not perform infusion.</p> <p>Employee D evaluation to be completed by May 15, 2009</p> <p>Employee E resigned</p> <p>Employee P completed 12/26/08</p> <p>Employee Q completed 12/18/08</p> <p>Employee R completed 1/30/09</p> <p>Employee T completed 5/6/08</p> <p>A RC 2 position has been hired whose responsibilities are the personnel files. A monthly report will be run of all upcoming performance evaluations and tracked by the RC 2. Reviews not completed timely will be shared with the Administrator who will ensure the evaluations are completed.</p>	

*5/15/09 Paula J. Williams for acceptably*

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G 134	Continued From page 14 whose date of hire was 5/1/00. The most recent performance assessment in this personnel record was completed in 2005.  Employee E is a Registered Nurse whose date of hire was 1/8/07. The most recent performance assessment in this personnel record was dated 1/8/08. The record lacked a performance assessment for 2009.  Employee P is a Speech-Language Pathologist whose date of hire was 12/16/07. The personnel record lacked evidence of any performance assessments completed since the date of hire.  This information was reviewed with the acting Administrator on 02/11/09. No further information was provided.	G 134			
G 138	484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE  The skilled nursing and other therapeutic services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least 1 year of nursing experience and is a public health nurse).  This STANDARD is not met as evidenced by: Based on a review of the personnel file for the employee functioning as Director of Clinical Management (DCM) from September 15, 2008 until January 19, 2009 and the employee "acting" in the role of Director of Clinical Management as of February 4, 2009, and interviews with the previous and current Administrators, evidence is lacking that the agency appointed a qualified, experienced registered nurse to be responsible	G 138  5/15/09 acceptable procedure	G138 484.14 (d) Supervising Physician or Registered Nurse  Hiring for management roles (DCM, MCP, and Administrator) will follow the company and state guidelines and experience /education requirements. It will be the AVP/designee responsibility to ensure only qualified professionals are hired.  To address the needs of the new MCP staff a clinical management course has been scheduled for the week of May 11, 2009. It is a three day course. This course includes but not limited to: 1.) Concepts of PI: adverse events; Medicare outcome reports; how to complete a chart audit; how to handle a complaint, incidents; billing compliance audits; how to run and analyze patient management reports; how to review an OASIS and POT.	5/13/09	



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G 138	Continued From page 15 for supervision of all skilled nursing and therapeutic services.  Specifically, both the previous and acting DCM lack evidence of home care experience. Furthermore, evidence is lacking that the agency ensured that each of these candidates were oriented to the responsibilities of the position.  Failure to ensure that the supervising nurse meets the qualifications of the position resulted in negative outcomes for seven patients: # 1, 2, 6, 26, 27, 30, 37 and the potential for negative outcomes for the entire patient population.	G 138	Outcomes of the orientation chart audits performed by the MCP/Designee will be reviewed monthly by the Administrator/DPS and discussed with the educator and also at the weekly MCP meetings. The results will be presented at the quarterly PAC meetings for additional recommendation for improvement as necessary. The current Administrator/DPS meets the criteria for the position. The search continues and was elevated to the AVP of Recruiting level for a qualified DPS. The company has even approved paying for relocation if necessary to find the right qualified candidate for this position. The candidate when identified will be interviewed not only by the Administrator but also the VP of Clinical Operations.	5/27/09	
G 140	484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE  Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).  This person, or similarly qualified alternate, participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.  This STANDARD is not met as evidenced by: Based on a review of 41 clinical records, interviews with the previous and current Administrator, interviews with the previous and acting Director of Clinical Management (DCM), review of agency policies and procedures, and review of personnel files, evidence is lacking in 39 records that the following supervisory responsibilities are being performed:	G 140	The Administrator/DPS is responsible for compliance with the orientation process,  and hiring of competent staff that meet the criteria/standards of the position.	5/15/09 accept table Paula J. Williams RN LSC	

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G 140	Continued From page 16  o Ensuring that nurses providing care are qualified, oriented to the position, and have been evaluated as competent in the skills they are assigned to perform independently. Specifically, 6 out of 6 skilled nurses hired within 6 months prior to the survey lack evidence of either a completed orientation program or a skills competency evaluation. See G 134  o Ensuring that nurses are assigned tasks that are only within their allowable scope of practice per New York State Education Department Licensure requirements. Specifically, the agency is routinely assigning Licensed Practical Nurses (LPN) to visit patients who have reported changes in condition and who require assessment. Patient assessment is beyond the LPN scope of practice. As outlined in Title VIII Education Law, Article 139 - Nursing  o Ensuring that Supervising Nurses are aware of the current status of each patient; that skilled nurses are providing comprehensive patient assessments and reassessments; that the plan of care developed is comprehensive and meets all patient needs; that the physician is consulted when changes in the patient's condition occur. G144, 159, 164, 171, 172  o Ensuring that coordination/case management is being performed consistently and that all pertinent patient information is communicated to all individuals providing care G143, 144  o Ensuring that the plan of care is being followed and that patients are not discharged from service prior to physician consultation/approval and prior to the development of a safe and adequate	G 140	All new clinical staff will be trained through the newly revised clinician associate orientation and follow the checklist of their discipline specific skill and requirements in their entirety. With joint visits with their preceptor skills will be validated as observed by the preceptor. In addition as new skills need to be observed, it will be scheduled with a like discipline already providing the skilled care for demonstrated competency and ability to perform that skill set. The skills checklist will be updated as new skills are verified. In addition a skill fair is being scheduled by May 22, 2009. <i>Current staff is included in this as well.</i> Staff was in-serviced on care coordination on: Liverpool: 3/31/09 Auburn: 3/24/09 Oswego: 4/7/09  An in-service on scope of practice is scheduled for: Liverpool: 5/21/09 Oswego: 5/19/09 Auburn: 5/20/09  OASIS training classes are provided monthly; This is training in how to assess the patient and complete an OASIS assessment. From this assessment how to identify patient needs and create a POC.		

*05-15-09 Paula Williams RN*  
*Acceptable*

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G 140	Continued From page 17 discharge plan. G158, 159, 164  Failure to provide adequate supervision has led to unmet patient needs, negative outcomes for seven patients: #1, 2, 6, 26, 27, 30, 37 and the potential for negative outcomes for the agency patient population.	G 140	Discharge Planning In-service is scheduled for: Liverpool: 5/21/09 Auburn: 5/20/09 Oswego: 5/19/09	
G 143	484.14(g) COORDINATION OF PATIENT SERVICES  All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care:  This STANDARD is not met as evidenced by: Based on a review of 37 clinical records (patients 1-10, 12-28, 30-41) for patients receiving skilled nursing and at least one other service, agency policies and procedures, and interviews with the acting Administrator and Supervising Nurses, evidence is lacking in 17 clinical records, that skilled nurses are functioning in the role of case management/coordination. Patients # 1-4, 6, 8, 11, 15, 19, 23, 24, 27, 30, 31, 34, 36, 37.  Although each patient is assigned an RN case manager who is responsible for patient care and supervision, the case manager failed to ensure the following:  - significant information is being exchanged between all individuals responsible for developing and implementing the plan of care.  - physicians are alerted promptly to changes in the patient's condition which may warrant immediate action or a modification in the plan of	G 143	The MCP reviews 100% of the SOC Assessment and the POC. In addition case conferences occur at the SOC, resumption of care, recertification, and prior to discharge. Case conferences occur with wound care patients and with changes in the patient's condition. Evidence of these conferences will be present in the medical record.  In order to facilitate care coordination field staffs were assigned to teams. In this team each 2RN staff has an assigned LPN to be a part of the care team providing care to the patient. The PT staff is assigned a PTA in the same model. The RN and PT are responsible to assign visits to the LPN/PTA staff. The LPN/PTA will call and update the case manager with the visits made daily. This will be documented in the medical record. The MCP of the team is responsible to facilitate this model.	5/27/09  5/27/09

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G 143	<p>Continued From page 18 care.</p> <p>- case managers are providing communication and oversight to Licensed Practical Nurses (LPNs) to ensure that the plan of care is implemented and changes in the patient's status is reported to the physician.</p> <p>Failure to ensure that skilled nurses are functioning in the role of case management/coordination has resulted in negative outcomes for patients # 2, 26 and the potential for negative outcomes for the agency's entire patient population.</p> <p>1. Patient #26 was admitted to the agency on 12/10/2004 with diagnoses of Alzheimer's disease and urinary incontinence requiring an indwelling urinary catheter. The plan of care for the certification period 11/19/08 to 01/17/09 stated skilled nursing visits one (1) time a month for 2 months to assess the patient, and change the urinary catheter; home health aide visits 3 times a week for 1 week, then 5 times a week for 7 weeks.</p> <p>Evidence is lacking the RN case manager recognized changes in the patient's condition, reported these changes to the physician, and provided adequate supervision and oversight of the LPN. As a result of the RN's failure to provide adequate case coordination, the patient's condition deteriorated, and the patient was transported by ambulance to the hospital and subsequently died.</p> <p>Specifically, the RN case manager visited the patient twice weekly from 11/28/08 to 12/12/08. During these visits the skilled nurse documented</p>	G 143	<p>The MCP and RN/PT case manager is to be contacted for changes in patient condition. The MCP will ensure that a follow-up visit for assessment has been scheduled by the case manager. The case manager is to contact the MCP with the outcome of that visit. The MCP or patient case manager will contact the MD.</p> <p>Coordination of care in-services were completed on: Liverpool: 3/31/09 Auburn: 3/24/09 Oswego: 5/19/09</p> <p>The Administrator/DPS is responsible for the above coordination of care. This will be monitored for continued compliance with the Clinical Record Review. Disciplinary action will take place up to and including termination for staff not compliant with this regulation. Documentation of this disciplinary process will be filed in the personnel file.</p>		5/27/09

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G 143	<p>Continued From page 19</p> <p>the following changes in the patient's condition that were not reported to the physician or communicated to all staff responsible for providing care.</p> <p>On 11/28/08, 11:05 am, the RN case manager visited the patient to complete her monthly skilled nursing assessment and documented the following change in condition: heart rate was elevated to 100 beats per minute (bpm) (the patient's heart rate documented during monthly assessment visits from 07/2/08 to 11/14/08 ranged from 64 to 88 bpm); the patient's husband was having difficulty feeding the patient and the patient's urine was "more amber than usual". The RN failed to report the patient's increased heart rate and decreased ability to consume food to the physician.</p> <p>- on 12/01/08, the RN case manager documented that the patient's heart rate was now elevated to 108 bpm and respiratory rate was increased to 24. The RN case manager again documented that the patient had "darker" amber urine. The RN case manager failed to communicate the elevated heart rate and increased respiratory rate to the physician.</p> <p>On 12/01/08, at 7:30 pm the RN case manager (who was on-call) received a call from the patient's husband stating that the patient would not wake up. The RN case manager visited the patient and documented that the patient's heart rate was 104 bpm. and she was no longer alert as per the 11/14/08 assessment. Specifically, the RN case manager documented that the patient was responsive only to tactile stimuli by opening her eyes. The RN case manager also documented that the patient's urine output was</p>	G 143			

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NAME OF PROVIDER OR SUPPLIER

**GENTIVA HEALTH SERVICES LIVERPOOL**

STREET ADDRESS, CITY, STATE, ZIP CODE

**200 ELWOOD DAVIS ROAD  
LIVERPOOL, NY 13088**

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G 143	<p>Continued From page 20</p> <p>very low at 150 cc amber urine since 11 am. The skilled nurse documented that she attempted to contact the physician but was unable to reach him. At the bottom of the 12/01/08 skilled nursing visit note, the skilled nurse documented that on 12/02/08 that she called the physician and spoke to a nurse, however, the skilled nurse failed to document the details of what was discussed with the physician's nurse. The RN case manager failed to conduct a visit until 3 days later.</p> <p>On 12/04/08, the RN case manager documented a blood pressure of 74/64; that the blood pressure was low because of a poor blood pressure cuff fit; that the urine output was 200 cc, and contained flecks of red. Although the skilled nurse documented that she reported the patient's blood pressure, blood in urine and urine output to the physician, there was no documented response from the physician, and no evidence that the skilled nurse recognized the need to reassess the patient's blood pressure with a different blood pressure cuff to ensure accuracy of the blood pressure.</p> <p>An interview with the nurse at physician's office was completed by the surveyor on 02/25/09 at 2:30 pm to determine the extent of the information provided to the physician regarding the patient's condition. The physician's nurse told the surveyor that she looked in the patient's record and in the computerized phone log for a record of calls from the home care nurse. The only documented information was on 12/04/08 was an "FYI" regarding the patient's decreased urine output. The physician's nurse stated that they were not informed about the decreased blood pressure.</p>	G 143		

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G 143	<p>Continued From page 21</p> <p>The patient was not reassessed until 4 days later on 12/08/08. On 12/08/08 a different RN visited the patient and documented the following inconsistent findings: the nurse documented that the patient was unresponsive and that she was being fed by her husband.</p> <p>There was no evidence that the RN case manager communicated with the skilled nurse before or after the visit to discuss the patient's deteriorating condition. As a result of the lack of communication, the skilled nurse failed to assess the following: the patient's intake, skin turgor, mucous membranes and urine output to determine if the patient had increased symptoms of dehydration. Additionally, the skilled nurse failed to report the patient's decrease in responsiveness to the RN case manager or physician. The patient was never reassessed by an RN and was not visited by the LPN until 4 days later on 12/12/08.</p> <p>On 12/12/08, at 4:45 pm, the LPN visited the patient and documented that the patient was unresponsive, urine was dark amber, had a temperature of 99.1 and that she was "unable to hear" the patient's blood pressure. There was no evidence that the LPN reported the inability to hear the patient's blood pressure and low grade fever to the RN case manager or the physician.</p> <p>On 12/16/08, the patient was transported to the emergency department by ambulance and died.</p> <p>Although there is a document labeled a "late entry" note dated 12/17/08 which stated the following: "spoke to the nurse at MD office, unable to hear blood pressure at this time VS (vital signs) otherwise stable no change in orders</p>	G 143			

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G 143	<p>Continued From page 22.</p> <p>given", the surveyor contacted the physician's office on 02/25/09 at 2:30 pm to verify the information documented by the LPN in the late entry note. The nurse at the physician's office informed the surveyor that they had no record of a call from this agency on 12/12/08 and told the surveyor that "if they (the MD office) had received that information (unable to hear a blood pressure) they would have requested another visit be completed and that they would have documentation of the call".</p> <p>This record was reviewed with the Director of Clinical Management and Administrator 01/14/09 and with the acting Administrator and the acting Director of Clinical Management on 03/16/09. No further information was provided. The Director of Clinical Management stated that the agency reviewed the circumstances surrounding the patient's death and found no significant issues with the nursing care. The Director of Clinical Management did not address the issues regarding assignment of an LPN to provide assessments and the lack of LPN communication with the Supervising Nurse to report the inability to hear a blood pressure. The Director of Clinical Management also stated that the LPN did report the blood pressure issues to the physician and referred to the late entry note dated 12/17/08.</p> <p>2. Patient #2 was admitted to the agency 11/22/08 following an open reduction internal fixation of a hip fracture and a history of type II diabetes, hypertension, and pernicious anemia. The plan of care included: skilled nursing services for 3 times a week for 1 week and 2 times a week for 1 week to assess and instruct in medication management and compliance; physical therapy services 4 times a week for 1 week and 3 times a</p>	G 143	<p>PT/INR: each visit note should reflect that the values were communicated via T.C. at the time of the visit to the MCP in the office.</p> <p>The MCP will document the levels and the Coumadin dose the patient is on and then call in the levels to the MD office and fax in the results to the physician. The MCP will document all of this information on a separate form.</p> <p>Patient #2 Due to the care coordination issues identified with this patient, the PT/INR process has been updated. A conference call was completed with the branches on the new process on: April 7, 2009. <i>pt discharged</i></p>	5/27/09	

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G 143	<p>Continued From page 23</p> <p>week for 2 weeks to provide therapeutic exercises, and obtain a PT/INR (blood test to monitor the effectiveness of anticoagulant therapy) on Mondays and Thursdays.</p> <p>There is no evidence that the RN case manager coordinated with the physical therapist in the development of the plan of care and discussed possible changes in the plan of care related to the patient's medication non-compliance. This lack of communication among the physical therapist, physical therapy assistant and the RN case manager resulted in a negative outcome for the patient and admission to the hospital for emergent care.</p> <p>Specifically, the failure to communicate findings include the following:</p> <ul style="list-style-type: none"> <li>o Both the RN case manager and the physical therapist completed initial assessments on 11/22/08. During the initial physical therapy assessment visit conducted, the physical therapist documented that the patient had a language barrier and that the daughter assists with interpretation. The RN case manager failed to identify this crucial patient need and the physical therapist did not discuss the initial assessment findings with the nurse. The lack of communication between the RN case manager and the physical therapist resulted in failure to develop a coordinated plan which included assurance that an interpreter was available during patient visits conducted by agency staff.</li> <li>o on 11/24/08, at 2 pm, the physical therapy assistant (PTA) visited the patient to obtain a PT/INR. The PTA documented that she reported to the physician that the "patient was not taking</li> </ul>	G 143			

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G 143	<p>Continued From page 24</p> <p>Coumadin (anticoagulant)" and that the physician wanted to increase the patient's Coumadin dosage. The clinical record contained a case communication note dated 11/24/08 from the physical therapist documenting receipt of a call from the PTA that she did not see Coumadin in the pill box, and could not determine from the patient or caregiver if the patient was taking her medication correctly. The physical therapist also documented calling the RN case manager to notify her of the medication issue. There is no evidence that the RN case manager developed a coordinated plan to ensure that the patient was correctly taking her medication and that the physician was updated.</p> <p>Specifically, although the PTA visited the patient on 11/25/08, evidence is lacking that the skilled nurse visited the patient until 11/26/08 to assess the patient's medication compliance.</p> <p>o on 11/26/08 a different RN visited the patient and documented that the medications were discussed with the patient's daughter and family. This skilled nurse documented that she discussed the patients incorrect use of coumadin with the physical therapist. Evidence is lacking, however that a plan was coordinated with the physical therapist, physician, the RN case manager and the primary care giver that addresses the patient/caregivers need for increased supervision of medications including Coumadin changes.</p> <p>o on 11/28/08, the PTA visited the patient to obtain the results of the patient's blood test. The PTA documented that the patient's blood pressure was elevated and that she woke up with a headache. On her visit note, the PTA documented that she contacted the physician to</p>	G 143			

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G 143	<p>Continued From page 25</p> <p>report that the patient was not given her Coumadin since admission to the agency and that the physician requested changes in the Coumadin dosages. The PTA also wrote a case conference note dated 11/28/08, that she spoke to the Supervising Nurse, physical therapist and the RN case manager about the patient's headache, blood pressure and non-compliance with Coumadin. There was no documentation that the PTA informed the skilled nurse about the physician's request for changes in Coumadin dose. The RN case manager again failed develop a coordinated plan to ensure that the patient's now elevated blood pressure and medication compliance was monitored.</p> <p>Despite being informed about the patient's elevated blood pressure and medication non-compliance, the RN case manager failed to recognize the importance of conducting an assessment visit until 3 days later on 12/01/08.</p> <p>On 12/01/08, the RN case manager documented "compliant with medication regimen per daughter" and that there were no medication changes since the last nursing visit on 11/26/08.</p> <p>Evidence is lacking that the skilled nurse ever assessed the dose and frequency with which the patient was taking coumadin and the patient's compliance with Coumadin dose changes documented during the PTA visit on 11/28/08.</p> <p>The skilled nurse failed ensure a coordinated plan was developed to evaluate the patient's continued need for monitoring of blood pressure medication compliance and teaching prior to the RN case manager discharging the patient on 12/04/08.</p>	G 143			

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G 143	<p>Continued From page 26</p> <p>Specifically, the RN case manager visited the patient on 12/04/08 and documented that she instructed the patient to continue taking her medications as ordered. Despite the patient's history of medication non-compliance, the RN case manager failed to document a review of medications with the patient/caregiver, and failed to communicate with the physical therapist or physical therapy assistant to ensure that the patient's on-going blood pressure assessment, medication monitoring and teaching needs were met.</p> <p>Physical therapy visits were continued twice weekly from 12/04/08 to 01/12/09. During these visits, the patient experienced episodes of elevated blood pressure and medication non-compliance as follows:</p> <ul style="list-style-type: none"> <li>- on 12/22/08 the PTA documented a blood pressure of 194/86.</li> <li>- on 12/26/08 the PTA documented a blood pressure of 190/90</li> </ul> <p>During these visits the PTA either failed to document the patient's compliance with blood pressure meds or documented that the patient was non compliant.</p> <p>Although the physical therapist visited the patient on 12/29/08, and assessed the patient's blood pressure was normal, the physical therapist failed to recognize that the patient continued to be non compliant with medications and failed to assess the need for the reinstatement of skilled nursing services for teaching and assessment.</p> <p>o on 01/05/09, the PTA visited the patient and again documented an elevated blood pressure of</p>	G 143			

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G 143	<p>Continued From page 27</p> <p>170/100. The PTA documented that again the patient had not taken her blood pressure medications and failed to report the patient's non-compliance with the physical therapist.</p> <p>The PTA also visited the patient on 1/07/09 and 01/09/09, and documented that the patient's blood pressure was within normal limits, no review of medication compliance or communication with the physical therapist</p> <p>o on 01/12/09, the PTA attempted to visit the patient and told by the patient's caregiver that the patient was seen in the emergency room on 01/11/09 because she started to "pass out". The PTA documented in a case communication note dated 01/12/08, that the emergency room physician told her that patient was being over-medicated for blood pressure.</p> <p>Failure to communicate changes in the patient's blood pressure and medication non-compliance between the PTA and physical therapist and failure of the therapist to assess the patient for continues nursing services, resulted in an incomplete plan to address the patient's medication compliance.</p> <p>This record was reviewed with the acting Administrator and the Supervising Nurses on 02/03/09. An interview with the Director of Physical Therapy was conducted on 03/11/09. No further information was provided regarding the lack of communication.</p> <p>3. Patient # 19 was admitted to the agency on 09/19/08 with a primary diagnosis late effect cerebral vascular accident with cognitive deficits and secondary diagnoses of type II diabetes,</p>	G 143			

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G 143	<p>Continued From page 28</p> <p>hypertension, aphasia and a pressure ulcer of the heel. During the initial nursing assessment, the skilled nurse documented that the patient has expressive aphasia; dysphagia (swallowing difficulties) requiring a gastric feeding tube; tube feeding to be administered by the patient's wife and nothing by mouth (NPO).</p> <p>The lack of case management/coordination by the RN case manager and the lack of communication between the disciplines resulted in:</p> <ul style="list-style-type: none"> <li>- failure to develop a plan to ensure that the patient is safely managed at home</li> <li>- failure to report changes in the patient's status to the physician including changes in diet and medication compliance which may have resulted in aspiration pneumonia.</li> </ul> <p>During skilled nursing visits conducted between 10/15 and 10/23/08, the skilled nurse documented that the patient was eating and drinking. This is against the physician's orders dated 09/18/08 which stated nothing by mouth. The RN case manager failed to communicate the patient's non-compliance to the speech therapist (ST), occupational therapist (OT) and the physician or develop a plan to ensure that all disciplines providing care could assess the patient's safety risk regarding the potential for aspiration associated with eating.</p> <p>The occupational therapist and speech therapist documented during visits conducted on 10/23/08 that the patient had "failed his modified barium swallow" and that the patient continues to eat despite the risks of aspiration. The speech</p>	G 143	<p>Patient #19 The RN case manager has been placed on an action plan and on focused review of her documentation. She has been counseled that if a patient is non-compliant with the POC she must contact the MD. She has been reminded that as a case manager she needs to assess the patient with a wound weekly and anytime the patient's condition changes. She is in the middle of a 4 week plan to improve her documentation. If she does not improve in patient care and documentation, she will be terminated at that time. <i>Pt. discharged</i></p>	

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G 143	<p>Continued From page 29</p> <p>therapist documented that she spoke to the speech therapist at the hospital who recommended that as a result of the modified barium swallow test that the patient should remain NPO. Both the ST and OT documented that they discussed the risks of eating and aspiration with the patient and his wife, who informed the therapists that the patient is going to eat and drink if he wants to. The ST and OT failed to communicate the test results or the patient's plan to continue to eat despite the test results and the physician's orders.</p> <p>An LPN visited the patient at 5:30 pm on the same day and failed to assess the patient's oral intake. It is unclear that the LPN was aware of the events of the day regarding the patient's testing results and non-compliance and the risk for aspiration of food and fluid. No subsequent skilled nursing visit was conducted until 10/27/08, 4 days later.</p> <p>On 10/27/08, the RN case manager visited the patient and documented that the patient eats by mouth and has tube feedings 3 times a day. (the plan of care states nothing by mouth and tube feedings 5 times a day). Evidence is lacking that the RN was aware that the patient failed the modified barium swallow and was at continued risk for aspiration as identified by the OT and the ST on 10/23/08. The RN failed to inform the physician of the patient's refusal to follow the plan of care.</p> <p>On 10/29/08, the occupational therapist documented that the patient continues to consume oral intake even with the risks of aspiration, and there was discussion with the RN case manager and or physician consultation.</p>	G 143			

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G 143	<p>Continued From page 30</p> <p>On 10/29/08, the RN visited the patient and again failed to assess the patient's oral intake or the amount, frequency or type of tube feedings administered by the patient's wife.</p> <p>On 10/31/08, the licensed practical nurse (LPN) was scheduled to visit the patient, however, was told by the family that the patient was taken to the hospital for "palpitations". There was no skilled nursing follow-up until 6 days later and no contact with the physician or the hospital to determine if there was a change in the plan of care.</p> <p>On 11/06/08, a different LPN visited the patient and documented that the patient is "eating full meals, against what the physician wants, per the wife". Although the LPN documented that she reported her visit findings to the RN case manager, no skilled nursing visit was conducted until 5 days later on 11/11/08 and there was no communication with the ST, OT or the physician regarding the patient's non compliance and hospitalization documented on 10/31/08.</p> <p>Between 11/11/08 and 12/03/08, skilled nursing visits were conducted 2 to 3 times a week by LPNs and RNs. The skilled nurses continued to document that the patient was consuming oral intake. There is no evidence of communication between the RN case manager, ST, OT and physician.</p> <p>On 12/03/08, the RN visited the patient and documented a change in the patient's lung sounds. The RN documented that the patient had fine crackles at the lung bases. This change in the patient's condition, a possible symptom of aspiration, was not reported to the physician.</p>	G 143			



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G 143	<p>Continued From page 31</p> <p>On 12/12/08, an LPN visited the patient and documented that the patient had fine crackles. The LPN documented that she reported these abnormal lung sounds to the physician and as a result the physician requested that the patient go to the emergency room for an x-ray to rule out aspiration pneumonia. The patient refused to go due to a lack of transportation. Although, transportation was arranged, the patient refused to go to the emergency room. There is no evidence that the LPN discussed the above findings with the RN case manager and no evidence that the RN case manager developed a plan to ensure that the patient received a chest x-ray to rule out aspiration pneumonia.</p> <p>On 12/16/08, the social worker visited the patient to evaluate the need for transportation assistance and was informed by the patient's wife that the patient was eating and drinking. During the social work visit, the patient's physician called the patient and again stated that the patient needed a chest x-ray. Although the social worker reported this to the RN case manager, evidence is lacking that she develop a plan in collaboration with the physician to ensure that the obtained a chest x-ray.</p> <p>Additionally, although the skilled nurse visited the patient 3 times a week between 12/17/08 to 01/14/09, evidence is lacking that the patient ever had the chest x-ray done to rule out pneumonia or the the RN case manager communicated this to the physician.</p> <p>On 1/14/09 however, an LPN visited the patient and documented that the patient had diminished lung sounds, and was started on an antibiotic on</p>	G 143			

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G 143	<p>Continued From page 32</p> <p>1/12/09. The LPN documented on a case communication note dated 01/14/08 that the patient told her: "this pneumonia is viral related, not aspiration". Evidence is lacking that the RN case manager assessed the patient's condition or consulted with the physician to determine if the antibiotics were started due to aspiration pneumonia.</p> <p>This record was reviewed with the acting Administrator and Supervising Nurses on 02/11/09. No further information was provided.</p> <p>4. Patient # 33 was admitted to the agency on 12/03/08 with diagnoses of dementia, and mental retardation. The lack of case management/coordination by the skilled nurse and a lack of communication between the disciplines has led to the following:</p> <ul style="list-style-type: none"> <li>- lack of specific plan to ensure that the patient's psycho/social needs are met</li> <li>- lack of a plan to ensure that the patient is safe in his home when the caregiver is unavailable</li> </ul> <p>On 12/03/08 the skilled nurse visited the patient and documented that the patient was very forgetful, his mental status was deteriorating, he was dependent on his wife for everything; he had a history of suicide attempts, and his wife was overwhelmed. The 12/03/08 plan of care specified a social work evaluation was to be conducted within 7 days of admission. Evidence is lacking, however, the skilled nurse coordinated with the social worker and identified that the social work evaluation had not been conducted until 12 days after admission on 12/15/08.</p>	G 143	<p>Patient # 33 Patient has been discharged. RN and MSW have been counseled.</p>	

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G 143	<p>Continued From page 33</p> <p>On 12/15/08 the social worker conducted an initial assessment, and identified that the wife was "burned out". Additionally, the social worker documented that the patient was being left alone on Tuesdays and Thursdays when the wife attended classes, and that the wife was questioning the patient's safety during these times. Evidence is lacking that the social worker communicated this to the skilled nurse, and evidence is lacking that the SN or the social worker ever assessed whether the patient was safe being left alone, or coordinated a plan to address the caregiver's stress.</p> <p>Additionally, the social worker documented that she would refer the patient to the Department of Social Services (DSS) Personal Care Aide program for the Tuesdays and Thursdays when the patient was being left alone. Evidence is lacking: that this plan was communicated to the skilled nurse, that the DSS evaluation ever occurred, or that a plan was coordinated to ensure the patient was safe until the DSS evaluation was conducted.</p> <p>On 01/07/08 the skilled nurse documented in the Discharge Summary to the physician that "all possible services were in place". Evidence is lacking however, that the skilled nurse and social worker developed a safe discharge plan for the patient. Specifically, the skilled nurse and social worker failed to identify and report to the physician, that the patient had been discharged from home care services prior to the DSS services being in place, that the patient's safety status was in question, and that the primary caregiver was stressed.</p> <p>Additionally, the "Discharge Summary" which</p>	G 143			

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G 143	Continued From page 34  was sent to the physician indicated the patient was compliant with his diabetes management plan most of the time, which included finger stick blood sugar testing 2 times per day, and insulin injections on a sliding scale 2 times per day. The "Discharge Assessment", however, which was completed on the same day, indicated the patient failed to perform his diabetic regime at least one time per week.  On 02/06/09 the surveyor interviewed the social worker. The social worker stated that it was a "hard call" to determine if the patient was safe at home alone, but that she did not feel that any additional social work visits were needed.  On 02/06/09 the surveyor interviewed the Department of Social Services caseworker, who confirmed that they had not yet assessed the patient.  The patient record was reviewed with the acting Administrator and the Supervising Nurses on 02/09/09. No additional information was provided.	G 143			
G 144	484.14(g) COORDINATION OF PATIENT SERVICES  The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.  This STANDARD is not met as evidenced by: Based on a review of 41 patient records, agency policies and interviews with the acting Administrator and Supervising Nurses, evidence is lacking in 41 records, that case conferences	G 144	See G tag # 143		5/27/09

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G 144	Continued From page 35 are consistently being conducted as outlined in agency policy and procedures and that there is a mechanism for effectively communicating changes in the patient's condition. Patients # 1-41.  The agency's Coordination of Care/Case Management policy indicates that case conferences will take place: at the time of admission, at least every 60 days throughout the course of care, prior to discharge, and more frequently if necessary.  Lack of adequate coordination of care and case management has the potential for unmet patient needs and possible negative patient outcomes.  During interviews conducted with the acting Administrator and Supervising Nurses on 02/04/09, the Supervising Nurses stated that until 1/16/09, the case conferences were completed in a group setting with all disciplines. The documentation of the case conferences contained in the clinical records for all patients lacked a discussion of the patient's progress towards goals and was more of a report of the patient's current status. The Supervising Nurse stated that as of 01/16/09, the case conferences are being conducted by one on one meetings with the skilled nurse. A review of the documentation of "summary/case conference reports" for January 2009, identified that the documentation remained incomplete and the case conference reports were not signed by the Supervising Nurse who met with the skilled nurse.	G 144			
G 151	484.16 GROUP OF PROFESSIONAL PERSONNEL	G 151			

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G 151	Continued From page 36  This CONDITION is not met as evidenced by: o Failure to participate in an annual evaluation of the agency's program, including a review of the agency's policies and procedures, quality of services provided, and personnel qualifications G153  o Failure to evaluate if agency policy and procedure revision is necessary  o Failure to review the results of agency clinical record audits, develop appropriate action plans to resolve areas in need of improvement, and evaluate the effectiveness and need to revise actions plans G153, 250  o Failure to advise the agency on professional issues. G154  o Failure to evaluate the use of community resources and assist the agency in maintaining liaison with the community G154  The cumulative effect of the agency's lack of a functional Professional Advisory Committee to advise the agency on quality of care issues, resulted in negative outcomes for seven patients: #1, 2, 6, 26, 27, 30, 37 and the potential for negative outcomes for the agency's patient population and the potential for unmet patient needs.	G 151	Revised PI program and PAC to include the following measures: a.) Clinical Record Review results b.) New orientation chart audits c.) Personnel file audits d.) Quarterly policy reviews e.) RN case management case load reports f.) Results of the monthly team audits g.) Adverse events h.) Trends of complaints, incidents and infections i.) Inclusion of the AVP of Regulatory Affairs a member of the governing body is a member of the PAC committee. j.) Pac meetings are held quarterly. The committee will make recommendations on areas requiring improvement that are below expected performance/benchmark. k.) The Governing body will review action plans to determine if they are appropriate to return the deficient area to compliance.  Governing Body weekly calls with the VP of Clinical Operations; the AVP of Regulatory Affairs; the RVP of operations will be held with the Administrator until the conditions are lifted and then become monthly. The members of the calls will be sent Chart audit results; orientation chart audit results and case manager case load reports. These calls will be documented by the governing body.  The Administrator is responsible for all of the above outcomes.	5/19/09
G 152	484.16 GROUP OF PROFESSIONAL PERSONNEL  A group of professional personnel includes at least one physician and one registered nurse (preferably a public health nurse), and	G 152		4/21/09

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G 152	<p>Continued From page 37</p> <p>appropriate representation from other professional disciplines.</p> <p>This STANDARD is not met as evidenced by: Based on a review of the Agency's June 3, 2008 Annual Program Evaluation for 2007 and the minutes of the Professional Advisory Committee (PAC) meetings for 2007 and 2008, and interviews with the agency Administrator and Acting Director of Clinical Management (ADCM) on February 5, 2009, evidence is lacking that the agency's PAC conducts an annual/ongoing review of the services provided by the agency and its two branches.</p> <p>During an interview with the acting Director of Clinical Management on February 5, 2009, who was functioning as the agency Quality Improvement Director up until February 4, 2009, the ADCM stated that the agency supervisors conduct all clinical audits and develop an action plan to address quality issues. She stated that this information is then shared with the Professional Advisory Committee on a quarterly basis.</p> <p>Review of the PAC minutes for meetings on March 3, 2008, June 3, 2008, September 23, 2008, and December 2, 2008, lacks evidence that the committee is reviewing results of the trended data and following a consistent process for the resolution of problem areas. Specifically:</p> <ul style="list-style-type: none"> <li>- The trended data report for the 3rd quarter of 2008 identifies unacceptable percentages in the following areas in Liverpool and its two branches: clinical notes show</li> </ul>	G 152	<p>G 151 484.16 Group of Professional Personnel</p> <p>This includes G tags 152 153, 154.</p> <p>The 2008 annual program evaluation will be completed by members of the governing body the AVP of Regulatory Affairs, the VP of Clinical Operations and the Administrator. The review of this document will be reflected in the minutes of the first quarter 2009 PAC meeting which will be held May 19th.</p> <p>The summary of the quarterly statistics from the chart audits will be presented and an action plan developed to improve areas identified as needing improvement. The improvement will be monitored through comprehensive monthly chart audit results (are the quarterly comprehensive chart audits that are broken down into monthly audits for each quarter so that auditing is continuous) 20% of each team's patient census will be reviewed monthly. The RC 2 will assign the audits the team. The outcome of these audits will be discussed at the multidisciplinary monthly clinical record review meeting. Areas identified needing improvement will have an action plan to improve the documentation. The meetings will have minutes and the minutes will be reviewed at each sequential meeting to ensure the actions have been completed that we assigned the previous month. Each monthly audit score will be combined to provide the quarterly audit score.</p>		5/19/09

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G 152	<p>Continued From page 38</p> <p>evidence of following the plan of care (68%); complete wound assessment (75%); physician/supervisor notified of changes in patient condition (79%); Home Health Aide notes follow the personal care plan (71%); Home Health Aide is supervised every 14 days (71%).</p> <p>Minutes of the PAC meeting for the 3rd quarter of 2008, dated December 2, 2008 state: "Director of Performance Improvement reviewed and discussed the Quarterly audit report and action plan; Plan of Treatment being followed remains an area of concern for all branches. Plans to correct the areas of improvement reviewed and discussed". However, there is no evidence that each of the areas above were discussed and an appropriate action plan identified.</p> <p>- The trended data report for the 4th quarter identified unacceptable percentages in the following areas for Liverpool and its two branches: clinical notes show evidence of following the plan of care (47%); complete wound assessment (67%); physician/supervisor notified of any changes in patient condition (58%); Home health Aide notes follow the personal care plan (81%); Home Health Aide is supervised every 14 days (80%).</p> <p>The Professional Advisory Meeting minutes were not available at the time of the survey, the performance improvement action plan, failed to identify that there had been a significant decline in: clinical notes showing evidence of following the plan of care; wound assessments; and physician/supervisor notification of changes in patient condition from the third quarter. The action plan also lacked reference to or an</p>	<p>G 152</p> <p><i>5/15/09 accept</i> <i>Analy Williams</i></p>	<p><i>PAC</i></p> <p>The committee has expanded to have representation from the Therapy Rehab Directors, an OT; a sales team member so they can see how the referral process impacts PI, an open invitation to any field staff who want to attend. We are currently searching for a community representative.</p> <p>The Administrator/DPS is responsible for the chart audit outcomes and improvement. Continued non-compliance will result in disciplinary actions up to and including termination and the documentation of this disciplinary action will be placed in the personnel file.</p>		



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G 152	Continued From page 39 evaluation of the action plan from the previous quarter to determine why the trended data was showing no improvement in the agency's performance.	G 152			
G 153	Failure of the agency to ensure that the Professional Advisory Committee reviews agency policies and procedures and participates in the review of the agency's program, may result in negative outcomes for the patient population. 484.16 GROUP OF PROFESSIONAL PERSONNEL  The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.  This STANDARD is not met as evidenced by: See G 154	G 153	See G tag #152		
G 154	Failure of the agency to ensure that the Professional Advisory Committee reviews agency policies and procedures and participates in the review of the agency's program, may result in negative outcomes for the patient population. 484.16(a) ADVISORY AND EVALUATION FUNCTION  The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care	G 154			

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G 154	<p>Continued From page 40</p> <p>providers in the community and in the agency's community information program.</p> <p>This STANDARD is not met as evidenced by: Based on a review of the Agency's 2008 Annual Program Evaluation for 2007 and the minutes of the Professional Advisory Committee (PAC) meetings for 2007 and 2008, and interviews with the agency Administrator and Acting Director of Clinical Management on February 5, 2009, evidence is lacking that the agency's PAC conducts an annual/ongoing review of the services provided by the agency and its two branches.</p> <p>Specifically,</p> <ul style="list-style-type: none"> <li>- Minutes of the PAC meetings and the report of the agency's Annual Program Evaluation lack evidence that the PAC committee is reviewing agency policies and procedures. There is no evidence the PAC reviews all of the agency's policies and makes a determination of the effectiveness, appropriateness, and adequacy of those policies. Although the PAC committee completes a corporate form for the annual review, there is no evidence on what basis/information the evaluation is performed. Questions such as "were patient care services appropriate" are checked "yes" and "comments/recommendations:" are typed "none".</li> <li>- Evidence is lacking the PAC advises the agency on ways to maintain liaisons with the community. The Annual Program Evaluation includes a section which states: "Comments regarding service patterns and location responses</li> </ul>	G 154	See tag # 152		

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G 154	Continued From page 41 to changing community/client care needs". This area is left blank.  - There is no evidence the PAC provides advise to the agency on professional and clinical issues, either in the minutes of PAC meetings or in the body of the Annual Program Evaluation report.  Failure of the agency to ensure that the Professional Advisory Committee reviews agency policies and procedures and participates in the review of the agency's program, may result in negative outcomes for the patient population.	G 154	Revised PI program and quarterly PAC to include the following measures: a.) Clinical Record Review results b.) New orientation chart audits c.) Personnel file audits d.) Quarterly policy reviews e.) RN case management case load reports f.) Results of the monthly team audits g.) Adverse events h.) Trends of complaints, incidents and infections i.) Inclusion of the AVP of Regulatory Affairs a member of the governing body is a member of the PAC committee. j.) PAC meetings are held quarterly. The committee will make recommendations on areas requiring improvement that are below expected performance/benchmark. k.) The Governing body will review action plans to determine if they are appropriate to return the deficient area to compliance.	5/19/09
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  This CONDITION is not met as evidenced by: o Failure to consistently follow a written plan of care. G158  o Failure to implement a system which ensures: that plans of care are comprehensive and address each patient's needs. This survey identifies the agency's failure to develop individualized plans of care which include specific interventions necessary to adequately assess and treat patient conditions and address significant patient symptoms. G159  o Failure to consistently alert the physician when changes in the patient's condition suggest a need to modify the plan of care. G164  The cumulative effect of these systemic problems	G 156 <i>5/15/09 acceptable</i>	100% review by the MCP of all SOC assessments and the POT to ensure accuracy and that the POT is appropriate based on the assessment. This will be documented on the SOC tool.  SOC case conference within the first week of care to review the POC is appropriate to meet the patient's needs	5/27/09

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G 156	Continued From page 42 in the development and implementation of the plan of care resulted in a negative outcomes for seven patients: # 1, 2, 6, 26, 27, 30, 37 and the potential for negative outcomes for the agency's entire patient population and the potential for unmet patient needs.	G 156	As issues are identified field supervision will occur by the MCP/designee with the clinicians. These include but are not limited to: with lack of quality documentation and care issues; patients who have verbalized a compliant with services; New staff within 60 -90 days and existing staff will have their yearly supervisory visits per policy.	5/27/09
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.  This STANDARD is not met as evidenced by: Based on a review of 41 clinical records and interviews with the Supervising Nurses and acting Administrator, evidence is lacking in 18 records that the plan of care developed by the physician is followed by all disciplines providing care. Patients # 1, 2, 5, 6, 9, 10, 16, 17, 19, 23, 29-33, 37, 40, 41.  Failure to to ensure that the plan of care is followed has led to a negative outcome for patient #30 and the potential for negative outcomes for the agency's patient population.  1. Patient # 30 was admitted to the agency on 11/29/08 with a primary diagnosis of non-healing surgical wound and secondary diagnoses of insulin dependent diabetes, hypertension, chronic bronchitis, long term use of anticoagulant and therapeutic drug monitoring. The plan of care stated skilled nursing visits 1 to 3 times a week for 3 weeks then 2 times a month.  The skilled nurse failed to assess the effectiveness of the patient's pain management	G 158	To ensure return to compliance with following the plan of care educational sessions have been provided to the field staff. These include Care coordination and following the plan of care. See tag #140 Through this education and training evidence of the knowledge transfer will be identified through the chart audit process. Clinicians showing trends and patterns with following the plan of care will be placed on focus review by their MCP and will meet with the MCP/designee until audit scores return to benchmark.  The Administrator/DPS will place clinicians with continued non-compliance despite above interventions will be disciplined up to and including termination. This will be documented and placed in the personnel file.	

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G 158	<p>Continued From page 43</p> <p>regimen and compliance with the 4 pain medications ordered including: Fentanyl patch, Methadone, Lyrica, and a Lidoderm patch.</p> <p>Failure of the skilled nurse to adequately assess pain management as outlined in the plan of care resulted in the patient experiencing uncontrolled pain from 11/29/08 to 01/06/09.</p> <p>Specifically, the skilled nurse visited the patient 7 times between 11/29/08 and 01/06/09 and documented that the patient had a pain intensity of 10 on a scale of 0 to 10. The skilled nurse failed to assess the patient's use of each pain medication and failed to contact the physician to report the patient's uncontrolled pain.</p> <p>Additionally, the skilled nurse failed to follow the plan of care as follows:</p> <p>During the initial nursing assessment the skilled nurse documented that the patient had 6 wounds: two wounds located on the left stump and 4 wounds located on the right lower extremity including the shin, ankle and foot. Evidence is lacking that the skilled nurse provided treatments and assessments as outlined in the plan of care as follows.</p> <p>- the skilled nurse visited the patient 6 times between 12/03/08 and 1/06/09. Evidence is lacking that the skilled nurse ever observed/assessed the 4 wounds located on the patient's right lower extremity.</p> <p>- the plan of care included monitoring of the patient's compliance with blood sugar testing and administration of regular insulin coverage 4 times a day. There is no evidence that the skilled nurse</p>	G 158	<p>The MCP and RN/PT case manager is to be contacted for changes in patient condition. The MCP will ensure that a follow-up visit for assessment has been scheduled by the case manager. The case manager is to contact the MCP with the outcome of that visit. The MCP or patient case manager will contact the MD.</p> <p>The missed visit report which is run weekly by the scheduling staff will identify if RN visits were not completed as it identifies the clinician that missed the visits. The MCP/designee will contact the clinician to determine why the visit was not completed.</p> <ul style="list-style-type: none"> <li>• All MD orders must be followed or if not able to a written note/case communication must be completed to state why the POC was not followed.</li> <li>• The POC must be followed exactly as written</li> <li>• The POC must be holistic and identify all patients' needs</li> <li>• Changes in patient's condition must be assessed by a RN/PT and reported to the MD for any changes in the orders.</li> </ul> <p>This will be monitored through the chart audit process. See G tag #250</p> <p>The Administrator/DPS is responsible for the compliance with MD orders. Continued non-compliance will result in disciplinary actions up to and including termination and the documentation of this disciplinary action will be placed in the personnel file.</p>	

5/15/09 accup table  
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G 158	<p>Continued From page 44</p> <p>assessed the frequency for blood sugar monitoring or that the patient was correctly administering insulin per the sliding scale as outlined in the plan of care.</p> <p>- the plan of care includes measuring of the right lower extremity edema at each visit and reporting changes to the physician. The skilled nurse failed to measure the patient's right lower extremity during skilled nursing visits between 12/03/08 to 01/06/09.</p> <p>This record was reviewed with the acting Administrator and the Supervising Nurses on 02/04/09. No further information was provided.</p> <p>2. Patient # 19 was admitted to the agency on 09/19/08 with a primary diagnosis of late effect cerebrovascular accident and secondary diagnoses of type II diabetes, hypertension and peripheral vascular disease. The plan of care included: skilled nursing visits in decreasing frequency from 3 times a week for 2 weeks to 2 times a week for 2 weeks and once a week for 1 week; physical therapy, speech therapy, and occupational therapy services. The plan of care also included enteral feeding with 5 cans of feeding/day via a percutaneous endoscopic gastrostomy (PEG) and nothing by mouth (NPO); 2 wounds, one wound requiring daily dressing changes performed by the patient's caregiver.</p> <p>Skilled nurse failed to consistently assess the following as outlined in the plan of care:</p> <p>- nutritional status including a consistent assessment of the enteral feeding status and the spouse's ability to administer feedings. Specifically, during skilled nursing visits</p>	G 158	<p>See tag # 140 for education and training provided</p>	

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G 158	<p>Continued From page 45</p> <p>conducted between 09/19/08 to 10/11/08, the skilled nurse failed to assess and document the type and amount of tube feeding administered by the patient's spouse or if the patient was remaining NPO. The skilled nurse documented that on 10/15/08, the patient was eating solid food. Evidence is lacking that this was reported to the physician or that patient was educated regarding the risks of choking or aspiration.</p> <ul style="list-style-type: none"> <li>- status of the heel wound and the spouse's ability perform wound care to the right heel daily</li> <li>- status of the peg tube insertion site. The skilled nurse failed to assess the condition of the skin surrounding the insertion site and failed to assess if the patient's spouse is consistently providing "peg tube care"</li> <li>- status of medication administration/compliance. Specifically, the plan of care states that patient's medications are to be taken orally, however, the patient is NPO.</li> <li>- compliance with the twice daily blood sugar monitoring and insulin administration</li> </ul> <p>Failure of the skilled nurse to follow the plan of care and provide adequate assessment has placed the patient at risk for aspiration pneumonia. Specifically, on 12/12/08, the skilled nurse documented a change in the patient's lung sounds including crackles throughout his lungs, the physician requested that the patient go to the emergency room. There was no follow-up by the skilled nurse and no evidence of treatment until one month later on 01/14/09 when the skilled nurse documented that the patient was placed on antibiotics. Additionally, evidence is lacking that</p>	G 158			

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G 158	<p>Continued From page 46</p> <p>the skilled nurse ever communicated with the physician.</p> <p>This record was reviewed with the acting Administrator and the Supervising Nurses on 02/09/09. No further information was provided.</p> <p>3. Patient # 29 was admitted to the agency on 11/04/08 with a primary diagnosis of physical therapy and secondary diagnoses of hypertension, osteoarthritis and a history of falls. The plan of care included physical therapy visits 3 times a week for 4 weeks, then 2 times a week for 2 weeks. Evidence is lacking that the physical therapist visited the patient at the frequency specified in the plan and following a fall in which the patient sustained a laceration to the hand and a black eye.</p> <p>Specifically, the physical therapist only visited the patient twice a week between 11/08/08 to 12/03/08 not 3 times a week as outlined in the plan. Additionally, there were no physical therapy visits in the clinical record after the 12/03/08 visit and the plan of care specified that physical therapy visits should continue until 12/16/08, which was 6 weeks.</p> <p>The clinical record did contain a summary/case conference report note dated 12/10/08 written by the physical therapy assistant (PTA). In the case conference note, the PTA documented that she called the patient on 12/05/08 to schedule a visit and was told by the patient that she fell the day before, suffered a laceration to the right hand requiring stitches and a black eye. Evidence is lacking that the physical therapist continued to visit the patient at the frequency stated in the plan of care or assessed the need to update the plan</p>	G 158		



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G 158	Continued From page 47 of care to include a referral to skilled nursing to assess the patient's hand laceration.  During the record review on 01/20/09, the surveyor could find no further documentation since the 12/10/08 case conference document and requested the additional information from the Supervising Nurse.  On 01/21/09, the Supervising Nurse gave the surveyor a document which stated that the patient was discharged from the agency on 12/05/08. The surveyor asked the Supervising Nurse: why the document was not in the clinical record; why documentation of a case conference held on 12/10/08 was in the record; and why the patient was on the active patient roster if discharged on 12/05/08. The Supervising Nurse could not answer.  On 01/22/08, at 2:30 pm, the surveyor interviewed the physical therapist case managing the patient. The physical therapist stated that he did not go back to see the patient and that he could not explain why the clinical record contained a case conference note dated 12/10/08 which states that the physical therapist will revisit the patient.  Additionally, evidence is lacking that the physical therapist developed a safe discharge plan following the patient's fall on 12/4/08.	G 158		
G 159	484.18(a) PLAN OF CARE  The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional	G 159		

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G 159	<p>Continued From page 48</p> <p>requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 41 clinical records, interviews with the Supervising Nurses and acting Administrator, evidence is lacking in 23 records that the plan of care is of sufficient scope to adequately meet the needs of the patient. Patients # 1, 3-6, 8, 9, 10, 12, 14, 15, 21, 23, 24, 25, 27, 28, 30, 32, 38, 39, 40, 41.</p> <p>Failure to ensure that an adequate plan of care is developed to meet the needs of the patient has the potential for negative outcomes for the agency's patient population.</p> <p>Home Visit</p> <p>1. Patient # 1 was admitted to the agency on 11/26/08 with a primary diagnosis of urinary tract infection and secondary diagnoses of C-5 - C-7 quadriplegia and neurogenic bladder and bowel. The patient has a history of emergent care due to symptoms related to autonomic dysreflexia, a life threatening condition associated with a spinal cord injury. The plan of care dated 11/26/08 included skilled nursing visits 1 time a week for 1 week, 3 times week for 3 weeks, 2 times a week for 2 weeks then 1 time a week for 2 weeks.</p> <p>The plan of care failed to include the following which placed the patient at risk for negative outcomes resulting in hospital admissions related to the spinal cord injury:</p>	G 159	<p>Comprehensive OASIS training is provided each month to new and current clinicians needing reinforcement. This training includes identification of patient needs. Issues will be identified using the SOC audit tool. Deficient practices specific to a clinician will result in the RN meeting with the MCP/designee to do the corrections required and that the follow-up is complete</p> <p>The Administrator/DPS is responsible for compliance. Continued non-compliance will result in disciplinary actions up to and including termination and the documentation of this disciplinary action will be placed in the personnel file.</p>	5/27/09

*5/15/09  
acceptable Paula Miller*

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G 159	<p>Continued From page 49</p> <ul style="list-style-type: none"> <li>- direction for the skilled nurse to observe and report symptoms of autonomic dysreflexia to the physician. The symptoms are potentially life threatening and include the following: high blood pressure, blurred vision, pounding headache, nasal stuffiness, flushed face, red blotching on chest, sweating above level of injury, goose bumps, cool, clammy skin, nausea, and feeling anxious.</li> <li>- specific interventions regarding the patient's bowel regimen and the person responsible to perform bowel care</li> <li>- specific interventions related to the foley catheter care including emptying the catheter bag, washing around the catheter.</li> <li>- plan to irrigate the foley catheter to keep free of obstruction</li> <li>- plan to meet patient's needs when mother is working outside the home</li> <li>- plan for the application and removal of left knee brace including the person responsible</li> </ul> <p>This record was reviewed with the Supervising Nurses and the acting Administrator on 02/03/09. No further information was provided regarding the plan of care.</p> <p>Home Visit</p> <p>2. Patient # 15 was admitted to the agency on 12/22/08 with diagnoses of Parkinson's disease and constipation. The plan of care dated 12/22/08 included skilled nursing visits twice a week for 2 weeks and once a week for 2 weeks to assess</p>	G 159		

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G 159	<p>Continued From page 50</p> <p>vital signs including respirations, pain, neurological status and medication set-up. Evidence is lacking that an adequate plan of care was developed to meet the needs of the patient as follows:</p> <ul style="list-style-type: none"> <li>- the 12/22/08 initial nursing assessment indicates that the patient had not had a bowel movement in 6 days since 12/16/08 while in the hospital. Although there was a plan to relieve constipation, there is no plan to assess the patient's knowledge deficit regarding symptoms of constipation, including diet and fluid intake.</li> <li>- the skilled nurse documented during the initial nursing assessment that the patient lived alone, and the medications are pre-poured by the skilled nurse. The plan of care failed to address who is responsible for the following intervention: "an enema or suppository if no BM (bowel movement) in 3 days". Additionally, there is no plan for the patient to receive twice daily laxative that is ordered by the capful and can not be pre-poured.</li> <li>- the skilled nurse documented the following personal care deficits in the initial nursing assessment and the plan of care failed to address these needs: <ul style="list-style-type: none"> <li>- someone must assist the patient to don undergarments, slacks, socks and shoes</li> <li>- unable to use the shower or tub and is bathed in bed or bedside chair</li> <li>- transfers and ambulates with an assistive device</li> <li>- unable to prepare light meals</li> <li>- unable to do any laundry and housekeeping due to physical limitations.</li> </ul> </li> </ul>	G 159			

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G 159	<p>Continued From page 51</p> <p>On 01/27/09, the surveyor conducted an observational home visit with the occupational therapist at 1 pm. During the visit, the patient informed the surveyor that she was receiving aide service 5 days a week from a Licensed Home Care Services Agency (LHCSA). This record was reviewed with the Supervising Nurse and Administrator on 02/03/09, as of this date, the agency was unaware that the patient was receiving aide service from the Office for the Aging.</p> <p>On 03/05/09, the surveyor contacted the licensed agency that was providing aide service to the patient and interviewed the Director of Patient Services (DPS). The DPS stated that this patient is receiving personal care aide service from the Office of the Aging 5 days a week and has been since 12/16/08 when she was discharged from the hospital. During the interview with the Supervising Nurse on 02/03/08, she stated that she would look into the issue however, no further information was provided.</p> <p>3. Patient # 5 was admitted to the agency on 12/26/08 with a primary diagnosis of acute renal failure and secondary diagnoses of insulin dependent diabetes, hypertension, hypothyroidism, diabetic neuropathy and sleep apnea. The plan of care dated 12/26/08 stated skilled nursing twice a week for 2 weeks, once a week for 1 week then twice a month for 1 month to assess the patient fistula, assess vital signs, assess blood sugar monitoring. Evidence is lacking that the plan of care is of sufficient scope to ensure that the patient's needs are met as follows:</p> <p>- the plan of care failed to include an assessment</p>	G 159			

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G 159	<p>Continued From page 52</p> <p>of the patient's skin and a plan for the application and removal of bilateral leg wraps identified during the initial nursing assessment dated 12/26/08. Specifically, the skilled nurse documented "client states she no longer has ulcers or edema on her legs with the bilateral leg wraps".</p> <ul style="list-style-type: none"> <li>- the skilled nurse documented the following personal care deficits during the initial nursing assessment completed 12/26/08 however, the plan of care failed to address these needs:</li> <li>- totally dependent for grooming</li> <li>- totally dependent for dressing lower body</li> <li>- requires assistance or supervision to use the shower or tub</li> <li>- unable to transfer self but is able to bear weight or pivot</li> <li>- unable to plan and prepare meals, do laundry, or housekeeping</li> </ul> <p>The skilled nurse documented that she reviewed the plan of care with the physician following the initial nursing assessment. The physician ordered home health aide service 3 times a week. There is no evidence that the physician was informed that the patient would not be receiving, aide service as discussed during the initial nursing assessment.</p> <p>The above findings were reviewed with the Supervising Nurses and Administrator on 01/26/08. During the review, the surveyor questioned the discrepancy between the initial physician verbal order and the subsequent plan of care which lacks home health aide service. The Supervising Nurse stated that the patient was aware that "insurance doesn't cover home health</p>	G 159			

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G-159	Continued From page 53	G-159		
G 164	<p>aide". There was no assessment of how the patient's needs would be met without home health aide service.</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE</p> <p>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 41 clinical records, and interviews with the acting Administrator and the Supervising Nurses, evidence was lacking in 22 records that the physician is consulted when changes in the patient's condition occur that may require a change in the plan of care. Patients # 1, 2, 5-8, 14-16, 19, 22, 24-27, 29-33, 36, 40.</p> <p>Failure to ensure that the physician is notified of changes in the patient condition have resulted in negative outcomes for patient's #1, 6, 26, 30 and the potential for negative outcomes for the agency patient population.</p> <p>1. Patient #26 was admitted to the agency on 12/10/2004 with diagnoses of Alzheimer's disease and urinary incontinence requiring an indwelling urinary catheter. The plan of care for the certification period 11/19/08 to 01/17/09 stated skilled nursing visits one (1) time a month for 2 months to assess the patient, and change the urinary catheter; home health aide visits 3 times a week for 1 week, then 5 times a week for 7 weeks.</p> <p>Evidence is lacking the RN case manager recognized changes in the patient's condition that</p>	G 164	<p>The MCP reviews 100% of the SOC Assessment and the POC. In addition case conferences occur at the SOC, resumption of care, recertification, and prior to discharge. Case conferences occur with wound care patients and with changes in the patient's condition. Evidence of these conferences will be present in the medical record.</p> <p>In order to facilitate care coordination field staffs were assigned to teams. In this team each 2RN staff has an assigned LPN to be a part of the care team providing care to the patient. The PT staff is assigned a PTA in the same model. The RN and PT are responsible to assign visits to the LPN/PTA staff. The LPN/PTA will call and update the case manager with the visits made daily. This will be documented in the medical record. The MCP of the team is responsible to facilitate this model.</p> <p>The MCP, MD and RN/PT case manager is to be contacted for changes in patient condition. The MCP will ensure that a follow-up visit for assessment has been scheduled. The case manager is to contact the MCP with the outcome of that visit. as evidenced in the documentation</p>	<p>4/22/09 Continues</p> <p>5/11/09 Continues</p> <p>5/11/09 Continues</p>

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G 164	<p>Continued From page 54</p> <p>require physician consultation. As a result of the RN's failure to recognize and report changes in condition, the physician was not notified when the patient's condition deteriorated; was transported by ambulance to the hospital and subsequently died.</p> <p>Specifically, the RN case manager visited the patient twice weekly from 11/28/08 to 12/12/08. During these visits the skilled nurse documented the following changes in the patient's condition that were not reported to the physician.</p> <p>On 11/28/08 the skilled nurse documented an elevated heart rate of 100 beats per minute (bpm); the patient's husband was having difficulty feeding the patient and the patient's urine was "more amber than usual".</p> <p>On 12/01/08, the skilled nurse documented that the patient's heart rate was now elevated to 108 bpm and respiratory rate was now slightly increased to 24. The RN case manager again documented that the patient had "darker" amber urine.</p> <p>On 12/01/08, at 7:30 pm the skilled nurse on-call visited the patient at the husband's request stating that the patient would not wake up. The skilled nurse visited the patient and documented that the patient's heart rate remained elevated at 104 bpm, she was less alert than during the 11/14/08 assessment, that the urine output was very low at 150 cc amber urine since 11 am. The skilled nurse documented that she attempted to contact the physician but was unable to reach him. At the bottom of the 12/01/08 skilled nursing visit note, the skilled nurse documented that on 12/02/08 that she called the physician and spoke</p>	G 164	<p>Changes in patient condition are to be reported to: The MD with documentation stating the MD was contacted and any new interventions or changes in the POC written as a verbal order. If a LPN/PTA observes a change in condition they must report this to the RN/PT case manager and the MCP. The MCP is to contact the case manager to ensure the patients' needs are met and that the MD is aware. This is documented on a case communication form. Failure to follow</p> <p>process and reporting a change in condition will result in the disciplinary process for the clinician and the MCP. The DCM/designee is to monitor that this occurs. <i>through</i> Evidence in the chart audits that this review does not occur or has improved will be monitored as part of the audit and reported on monthly.</p> <p>See chart audit process G tag # 250</p> <p>The Administrator has the over-all responsibility to ensure this is compliant.</p>	5/15/09



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G 164	<p>Continued From page 55</p> <p>to a nurse, however, the skilled nurse failed to document the details of what was discussed with the physician's nurse.</p> <p>On 12/04/08, the skilled nurse documented a blood pressure of 74/64; that the blood pressure was low because of a poor blood pressure cuff fit; that the urine output was 200 cc, and contained flecks of red. Although the skilled nurse documented that she reported the patient's blood pressure, blood in urine and urine output to the physician, there was no documented response from the physician, and no evidence that the skilled nurse recognized the need to reassess the patient's blood pressure with a different blood pressure cuff to ensure accuracy of the blood pressure.</p> <p>An interview with the nurse at physician's office was completed by the surveyor on 02/25/09 at 2:30 pm to determine the extent of the information provided to the physician regarding the patient's condition. The physician's nurse told the surveyor that she looked in the patient's record and in the computerized phone log for a record of calls from the home care nurse. The only documented information was on 12/04/08 was an "FYI" regarding the patient's decreased urine output. The physician's nurse stated that they were not informed about the patient's deteriorating condition.</p> <p>On 12/12/08, at 4:45 pm, the LPN visited the patient and documented that the patient was unresponsive, urine was dark amber, had a temperature of 99.1 and that she was "unable to hear" the patient's blood pressure. There was no evidence that the LPN reported the inability to hear the patient's blood pressure and low grade</p>	G 164			

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G 164	<p>Continued From page 56</p> <p>fever to the RN case manager or the physician.</p> <p>On 12/16/08, the patient was transported to the emergency department by ambulance and died.</p> <p>Although there is a document labeled a "late entry" note dated 12/17/08 which stated the following: "spoke to the nurse at MD office, unable to hear blood pressure at this time VS (vital signs) otherwise stable no change in orders given", the surveyor contacted the physician's office on 02/25/09 at 2:30 pm to verify the information documented by the LPN in the late entry note. The nurse at the physician's office informed the surveyor that they had no record of a call from this agency on 12/12/08 and told the surveyor that "if they (the MD office) had received that information (unable to hear a blood pressure) they would have requested another visit be completed and that they would have documentation of the call".</p> <p>This record was reviewed with the Director of Clinical Management and Administrator 01/14/09 and with the acting Administrator and the acting Director of Clinical Management on 03/16/09. No further information was provided. The Director of Clinical Management stated that the agency reviewed the circumstances surrounding the patient's death and found no significant issues with the nursing care. The Director of Clinical Management did not address the issues regarding assignment of an LPN to provide assessments and the lack of LPN communication with the Supervising Nurse to report the inability to hear a blood pressure. The Director of Clinical Management also stated that the LPN did report the blood pressure issues to the physician and referred to the late entry note dated 12/17/08.</p>	G 164			

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G 164	<p>Continued From page 57</p> <p>2. Patient # 1 was admitted to the agency on 11/26/08 with a primary diagnosis of urinary tract infection and secondary diagnoses of C-5 - C-7 quadriplegia and neurogenic bladder and bowel. Evidence is lacking that the skilled nurse reported changes in the patient's condition which resulted in an emergency room visit for bronchitis and a urinary tract infection.</p> <p>Specifically:</p> <ul style="list-style-type: none"> <li>- On 12/12/08, the LPN documented patient had a temperature of 99.1, and had a blister on the left heel which was not previously noted and was covered with a Band-Aid. There was no call to the physician to report the patient's low grade temperature and new blister.</li> <li>- On 12/20/08 the skilled nurse again documented that the patient was having a low grade temperature, dizziness and nausea and vomiting. According to the patient's mother, the patient was in the emergency room on 12/17/08 and 12/18/08. The skilled nurse failed to contact the physician to discuss any changes in the plan of care as a result of the hospital visits, or to report the low grade temperature, nausea and vomiting and dizziness.</li> </ul> <p>As a result, the hospital records show that the patient was also seen in the emergency room on 12/22/08 which resulted in the patient being placed on antibiotics for symptoms of a urinary tract infection and green sputum caused by bronchitis.</p> <p>The skilled nurse visited the patient on 12/24/08 and documented "patient states on antibiotic not</p>	G 164			

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G 164	<p>Continued From page 58</p> <p>sure what". The skilled nurse then wrote out Vantin 200 mg 2 tabs 2 times a day. The skilled nurse relied on the patient's information, there is no evidence that the skilled nurse reviewed the prescription bottle. The skilled nurse failed to report that the patient had been seen in the emergency room and confirm the medication change or discussed an updated plan of care following the emergency room visit.</p> <p>This record was reviewed with the Supervising Nurses and the acting Administrator on 02/03/09. No further information was provided regarding the plan of care.</p> <p>3. Patient #6 was admitted to the agency on 11/20/08 with a primary diagnosis of after care following a total hip replacement and secondary diagnoses of type II diabetes, ulcer of the heel and midfoot and hypertension. Although the skilled nurse documented that she contacted the physician following the initial nursing assessment on 11/20/08, evidence is lacking that she informed the physician of the following abnormal findings:</p> <ul style="list-style-type: none"> <li>- wheezing throughout his lung fields, a loose cough</li> <li>- can only ambulate 10 feet without becoming fatigued and short of breath with ambulating less than 20 feet.</li> <li>- confusion during the day and night but not constantly</li> <li>- requires assistance to groom, dress upper and lower body, bathe, toilet, and ambulate</li> <li>- patient's wife is overwhelmed with the patient's care</li> </ul> <p>Additionally, evidence is lacking that the skilled</p>	G 164			

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G 164	<p>Continued From page 59</p> <p>nurse reported the following changes in the patient's condition as documented in the 11/26/08, skilled nursing assessment visit.</p> <ul style="list-style-type: none"> <li>- weight 130 pounds - representative of a 6 pound weight loss in 6 days. The nurse failed to assess the patient's appetite, food and/or fluid intake and report to the physician.</li> <li>- abnormal respiratory assessment which included an assessment "rhonchi right and left".</li> <li>- if the care giver continued to be overwhelmed with the patient's care.</li> </ul> <p>The very next morning, on 11/27/08, the patient's condition deteriorated to the point that the patient's wife contacted the on-call nurse who visited the patient and arranged for the patient admission to the hospital.</p> <p>A review of the hospital record documented that the patient was admitted with shortness of breath, wheezes and crackles throughout his lung fields. The patient also reported to the emergency room physician that his symptoms started 2-3 days ago.</p> <p>This record was reviewed with the acting Administrator and Supervising Nurses on 02/03/09. No further information was provided.</p> <p>4. Patient # 30 was admitted to the agency on 11/29/08 with a primary diagnosis of non-healing surgical wound and secondary diagnoses of insulin dependent diabetes, hypertension, chronic bronchitis, long term use of anticoagulant and therapeutic drug monitoring. The plan of care dated 11/29/08, stated skilled nursing visits 1 to 3</p>	G 164		

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G 164	Continued From page 60 times a week for 3 weeks then 2 times a month to assess pain and medication effectiveness, the plan also stated that the physician ordered 4 pain medications: Fentanyl patch, Methadone, Lyrica, and a Lidoderm patch.  The skilled nurse failed to report the patient's ineffective pain management regimen to the physician, resulting in the patient experiencing uncontrolled pain from 11/29/08 to 01/06/09.  Specifically, the skilled nurse visited the patient 7 times between 11/29/08 and 01/06/09 and documented that the patient had a pain intensity of 10 on a scale of 0 to 10.  Evidence is lacking that the skilled nurse assessed the patient's consistent use of pain medication as ordered and failed to report the patient's uncontrolled pain to the physician.  This record was reviewed with the acting Administrator and Supervising Nurses on 02/04/09. No further information was provided.	G 164			
G 168	484.30 SKILLED NURSING SERVICES  This CONDITION is not met as evidenced by: o Failure to ensure that skilled nurses are instructed and adequately trained to perform comprehensive nursing assessments which identify each patient's individual needs. Nursing assessments are incomplete and do not consistently reflect the patient's baseline status. See G171  o Failure to consistently reevaluate the patient's condition. See G172	G 168			

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G 168	Continued From page 61  o Failure to coordinate care and services. See G143, G144  o Failure to ensure that skilled nurses receive adequate training to ensure competency in the skills necessary to implement each patient's plan of care. See G140  The cumulative effect of these systemic issues related to the assessment process resulted in negative outcomes for seven patients: # 1, 2, 6, 26, 27, 30, 37 and the potential for negative outcomes for the agency's patient population.	G 168	See tag # 140  OASIS training classes are provided monthly; this is training in how to assess the patient and complete an OASIS assessment. From this assessment how to identify patient needs and create a POC. It is provided to new and current clinicians needing to review the OASIS assessment and creating the POT.		monthly
G 171	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse makes the initial evaluation visit.  This STANDARD is not met as evidenced by: Based on a review of 38 clinical records for patient's admitted to the agency by a registered nurse (Patients # 1-10, 12-27, 30-41), and interviews with the acting Administrator, Supervising Nurses and agency staff, evidence is lacking in 19 records that the initial nursing assessment is of sufficient scope that it identifies the needs of the patient. Patients # 1, 2, 5, 6, 7, 8, 9, 12, 15, 19, 24, 27, 30, 31, 33, 37, 38, 39, 40.  Failure to ensure that a complete and accurate initial nursing assessment is developed has led to the failure of the skilled nurse to develop a plan of care to meet the patient's needs has the potential for negative outcomes for the agency patient population.	G 171	Team audit process: As part of the quarterly comprehensive record audit each month 20% of that team's census will be reviewed by a MCP/designee. The team's audit scores will be reviewed at the monthly record review meeting and recommendations for improving areas below benchmark will be discussed. The MCP is on the committee and has the accountability that her teams audit scores and documentation is compliant.  Peer review process: The MCP/designee on each team will assign 2 charts to be reviewed each quarter by each RN/PT. The outcome of the peer reviews (part of the comprehensive chart audits and integrated into that statistic) will be discussed at the monthly team meetings.  Each monthly statistics are compiled into the quarterly statistic presented at the quarterly PAC meetings.  The Administrator/DPS is responsible for audits to be completed and documentation shows compliance.		5/27/09  5/27/09

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>337255</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/15/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>GENTIVA HEALTH SERVICES LIVERPOOL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 ELWOOD DAVIS ROAD LIVERPOOL, NY 13088</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 171	<p>Continued From page 62</p> <p>1. Patient # 1 was admitted to the agency on 11/26/08 with a primary diagnosis of urinary tract infection and secondary diagnoses of C-5 - C-7 quadriplegia and neurogenic bladder and bowel. The initial assessment documented that the patient had a history of emergent care due to symptoms related to autonomic dysreflexia, a life threatening condition associated with a his spinal cord injury, which includes:</p> <p>high blood pressure, blurred visions, pounding headache, nasal stuffiness, flushed face, red blotching on chest, sweating above level of injury, goose bumps, cool, clammy skin, nausea, and feeling anxious</p> <p>The initial nursing assessment failed to include an assessment of:</p> <ul style="list-style-type: none"> <li>- the patient/caregiver's knowledge and treatment of symptoms of autonomic dysreflexia.</li> <li>- how care would be provided when the patient's mother was working.</li> <li>- assessment patient's actual functional limitations. Specifically, the skilled nurse documented that the patient has "upper extremity strength", however, the skilled nurse failed to assess the patient's use of a wheelchair, and the patient's ability to transfer.</li> <li>- the patient's safety related to the ability to leave the home in case of an emergency. The skilled nurse failed to assess if the patient had an emergency plan and if the patient could safely get out of the home in case of a fire.</li> <li>- who is responsible for emptying the urinary</li> </ul>	G 171	<p>The MCP reviews 100% of the SOC Assessment and the POC. In addition case conferences occur at the SOC, resumption of care, recertification, and prior to discharge. Case conferences occur with wound care patients and with changes in the patient's condition. Evidence of these conferences will be present in the medical record.</p> <p>In addition the review of the assessments and POT by the MCP as part of the supervision of their field staff now will be measured by individual team audit scores. The MCP will be measured by the team's over-all score. They will meet with the DCM/designee monthly to review their audit scores. Those MCP teams where documentation needs improvement the MCP will be responsible to work with their field staff to make sure compliance is obtained. If the audits continue to show non-compliance the clinician and the MCP will be disciplined by the DCM/designee up to and including termination. The audits will be on-going to ensure on-going compliance.</p> <p><i>This will be documented and placed in the personnel file. The Administrator /DPS is</i></p>		<p>05/07/09</p> <p>5/07/09</p>

*responsible for compliance*



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G 171	<p>Continued From page 63 catheter collection bag at least daily.</p> <ul style="list-style-type: none"> <li>- specifics related to the implementation of the bowel program 2-3 times a week by the mother, including the mother's ability and availability to perform.</li> <li>- how the patient's personal care needs would be met. Specifically, the skilled nurse documented that the patient was: <ul style="list-style-type: none"> <li>- totally dependent for grooming</li> <li>- totally dependent for dressing upper and lower body</li> <li>- unable to use the shower or tub</li> <li>- totally dependent for toileting</li> <li>- the patient's ability to transfer was unknown and not assessed</li> <li>- unable to ambulate uses a wheelchair but is able to wheel self independently</li> <li>- unable to plan and prepare meals, do laundry, or housekeeping</li> </ul> </li> </ul> <p>This record was reviewed with the Supervisory Nurse and the Administrator on 02/02/09. No information regarding the above findings was provided.</p> <p>2. Patient # 15 was admitted to the agency on 12/22/08 with diagnoses of Parkinson's disease and constipation. Evidence is lacking that the initial nursing assessment is of sufficient scope to identify the patient's needs as follows:</p> <ul style="list-style-type: none"> <li>- the patient has an admitting diagnosis of constipation and informed the skilled nurse during the assessment visit that she did not have a bowel movement for 6 days after discharge from the hospital on 12/16 to 12/22/08. The skilled</li> </ul>	G 171	<p>The MCP staff will increase their field supervision with their field staff especially those with poor quality of documentation, care coordination and difficult to serve patient, patients/care givers who have voiced a complaint. <i>The current policy states annual supervision</i></p> <p>The Administrator will have conference calls with the MCP bi-weekly and meet in person with the MCP staff the other weeks. This will be to review progress of the plan of correction, audit scores, educational needs, outcome of orientation, case loads and complaints, incidents and any other issues/concerns or needs the MCP staff has.</p> <p>The Administrator has the over-all accountability of the compliance with these standards.</p>		

*acceptable Paula J. Williams*  
*5/15/09*

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G 171	<p>Continued From page 64</p> <p>nurse failed to assess the patient's usual bowel pattern, the current use of bowel preparations to ensure regular bowel movements, and no evidence of teaching regarding when to notify the nurse and/or physician.</p> <ul style="list-style-type: none"> <li>- the skilled nurse documented that the patient should use an enema or suppository if no bowel movement in 3 days. The plan of care does not include orders for an enema or any type of suppository. Additionally, the skilled nurse failed to assess the patient's ability to self administer the enema or suppository.</li> <li>- the skilled nurse documented that the patient lives alone and has the following deficits in the performance of activities of activities of daily living: <ul style="list-style-type: none"> <li>- someone must put on undergarments, slacks, socks and shoes</li> <li>- unable to use the shower or tub and is bathed in bed or bedside chair</li> <li>- transfers and ambulates with an assistive device</li> <li>- unable to prepare light meals</li> <li>- unable to do any laundry and housekeeping due to physical limitations</li> </ul> </li> </ul> <p>The skilled nurse failed to recognize the need for home health aide assistance and did not develop a plan to meet the patient's personal care needs.</p> <p>The record was reviewed with the acting Administrator on 02/03/09. No further information was provided.</p> <p>3. Patient # 5 was admitted to the agency on 12/26/08 with a primary diagnosis of acute renal failure and secondary diagnoses of insulin</p>	G 171			

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G 171	<p>Continued From page 65</p> <p>dependent diabetes, hypertension, hypothyroidism, diabetic neuropathy and sleep apnea. Evidence is lacking that the initial nursing assessment is of sufficient scope that the patient's current needs are identified and an adequate plan of care is developed to meet those needs as follows:</p> <ul style="list-style-type: none"> <li>- the skilled nurse documented that the patient had decreased mobility and endurance, however, failed to assess the the patient's specific functional deficits.</li> <li>- the skilled nurse failed to observe the patient's lower extremities for skin breakdown and/or edema. Specifically, the skilled nurse documented "client states she no longer has ulcers or edema on her legs with the bilateral leg wraps".</li> <li>- the patient has a left upper arm fistula for hemodialysis, the skilled nurse failed to ensure that the fistula is functional by auscultating a bruit or palpating a thrill.</li> <li>- the skilled nurse documented the following deficits in performing personal care: <ul style="list-style-type: none"> <li>- totally dependent for grooming</li> <li>- totally dependent for dressing lower body</li> <li>- requires assistance or supervision to use the shower or tub</li> <li>- unable to transfer self but is able to bear weight or pivot</li> <li>- unable to plan and prepare meals, do laundry, or housekeeping</li> </ul> </li> </ul> <p>Although the skilled nurse identified the need for a home health aide 3 days a week. Evidence is</p>	G 171		

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G 171	Continued From page 66  lacking that patient ever received home health aide services to meet her needs and there was no indication in the initial nursing assessment why services would not be provided.  The above findings were reviewed with the Supervising Nurses and Administrator on 01/26/08. During the review, the surveyor questioned the discrepancy between the initial assessment and the subsequent plan of care which lacks home health aide service. The Supervising Nurse stated that the patient was aware that "insurance doesn't cover home health aide". There was no assessment of how the patient's needs would be met without home health aide service.	G 171		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse regularly re-evaluates the patients nursing needs.  This STANDARD is not met as evidenced by: Based on a review of 38 clinical records for patients receiving skilled nursing services (Patients # 1-10, 12-27, 30-41), and interviews with the acting Administrator and Supervising Nurses, evidence is lacking in 20 records that skilled nursing reassessments are of sufficient scope to identify changes in the patient's condition which may require re-evaluation and/or modification in the plan of care. Patients # 1, 2, 5, 6, 8, 9, 10, 15, 16, 19, 20, 21, 22, 23, 26, 27, 30, 31, 32, 41.  Failure to ensure that skilled nursing reassessments are of sufficient scope to identify changes in the patient's condition has led to	G 172	<i>See # tag 171</i>	

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G 172	<p>Continued From page 67</p> <p>negative patient outcomes for patients # 6, 26, 30, 37 and the potential for negative outcomes for the agency patient population.</p> <p>1. Patient #26 was admitted to the agency on 12/10/2004 with diagnoses of Alzheimer's disease and urinary incontinence requiring an indwelling urinary catheter. The plan of care for the certification period 11/19/08 to 01/17/09 stated skilled nursing visits one (1) time a month for 2 months to assess the patient and change the foley catheter, and home health aide visits 3 times a week for 1 week, then 5 times a week for 7 weeks.</p> <p>Evidence is lacking that the skilled nurse recognized changes in the patient's condition, that required immediate medical intervention, and reported these changes to the physician. The patient's condition worsened to the point that 2 days following a skilled nursing visit, the patient was transported to the emergency room and died.</p> <p>The skilled nurse failed to recognize that the elevation in heart rate and darker urine may be related to dehydration and require additional assessment of the patient's mucous membranes and skin turgor.</p> <p>Specifically, on 11/28/08 and 12/01/08, the skilled nurse visited the patient and documented that the patient had an increased heart rate and dark amber urine, there is no evidence that the skilled nurse assessed the patient's fluid intake, skin turgor or mucous membranes of the mouth related to dehydration.</p> <p>On 12/01/08, at 7:30 pm the skilled nurse (who was on-call) received a call from the patient's</p>	G 172			

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G 172	<p>Continued From page 68</p> <p>husband stating that the patient would not wake up. The skilled nurse visited the patient and documented that the patient's heart rate was 104 bpm. and she was responsive only to tactile stimuli by opening her eyes. (During previous visits from 07/02/08 to 11/14/08, the patient was alert but non-verbal). The skilled nurse also documented that the patient's urine output was very low at 150 cc amber urine from 11 am to 7:30 pm. The skilled nurse documented that she attempted to contact the physician but was unable to reach him. At the bottom of the 12/01/08 skilled nursing visit note, the skilled nurse documented that on 12/02/08 she called the physician and spoke to a nurse. The skilled nurse failed to document the details of what was discussed with the physician's nurse.</p> <p>The skilled nurse failed to conduct a visit until 2 days later on 12/04/08 at 9:00 am. During the visit, the skilled nurse documented a blood pressure of 74/64, noted that the blood pressure was low because of a poor blood pressure cuff fit and that the patient's urine output was 200 cc and contained flecks of red. The skilled nurse did not identify the last time the urine collection bag was emptied. The skilled nurse documented that she reported the patient's blood pressure, blood in urine and decreased urine output. There was no response from the physician documented and no evidence that the skilled nurse recognized the need to immediately reassess the patient's blood pressure with a different blood pressure cuff to ensure accuracy of the blood pressure or to send the patient to the hospital for emergent care. The skilled nursing failed to reassess the patient until 4 days later on 12/08.</p> <p>On 12/08/08, the skilled nurse documented the</p>	G 172			

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G 172	<p>Continued From page 69</p> <p>following inconsistent findings: the nurse documented that the patient was unresponsive and that she was being fed by her husband. The skilled nurse failed to assess the patient's intake, skin turgor, mucous membranes or urine output related to determine if the patient had increased symptoms of dehydration and failed to recognize the seriousness of the patient's worsening symptoms. Additionally, the skilled nurse failed to report the patient's decreased responsiveness to the Supervising Nurse or the physician.</p> <p>The skilled nurse failed to recognize the need for an assessment by a registered nurse and assigned a licensed practical nurse (LPN) to reassess the patient. This resulted in the patient never being assessed by an RN again and not being visited by the LPN until 4 days later on 12/12/08.</p> <p>On 12/12/08, at 4:45 pm, the LPN visited the patient and documented that the patient was unresponsive, urine was dark amber, had a temperature of 99.1 and that she was "unable to hear" the patient's blood pressure. There was no evidence that the skilled nurse contacted the physician during the visit and failed to report the patient's condition to the RN case manager or the Supervising Nurse and pursue emergent care for the patient.</p> <p>On 12/16/08, the home health aide documented that patient was transported to the hospital ambulance and died.</p> <p>This record was reviewed with the Director of Clinical Management and Administrator 01/14/09. The Director of Clinical Management stated that the agency reviewed the circumstances</p>	G 172		

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G 172	<p>Continued From page 70</p> <p>surrounding the patient's death and found no significant issues with the nursing care. The Director of Clinical Management also stated that the LPN reported the blood pressure issues to the physician and referred to the late entry note dated 12/17/08. The skilled nurse documented in the late entry note dated 12/17/08: "spoke to the nurse at MD office, unable to hear blood pressure at this time VS otherwise stable no change in orders given".</p> <p>As a follow-up to the clinical record review, the surveyor contacted the physician's office on 02/25/09 at 2:30 pm to verify the information provided by the LPN in the late entry note. The nurse at the physician's office informed the surveyor that they had no record of a call from this agency on 12/12/08 and told the surveyor that "if they (the MD office) had received that information (unable to hear a blood pressure) they would have requested another visit be completed and that they would have documentation of the call".</p> <p>This information was shared with the acting Administrator on 03/16/09. No further information was provided.</p> <p>2. Patient #6 was admitted to the agency on 11/20/08 with a primary diagnosis of after care following a total hip replacement and secondary diagnoses of type II diabetes, ulcer of the heel and midfoot and hypertension. The plan of care dated 11/20/08 to 01/28/09 stated skilled nursing visits twice a week to perform PT/INRs, (a blood test to determine blood clotting time), make coumadin adjustments, check pedal pulses every visit, assess wound care to the left heel that the spouse is to perform daily, monitor glucometer</p>	G 172		



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G 172	<p>Continued From page 71</p> <p>readings, that the patient independently records twice a day.</p> <p>Failure to recognize the needs of the patient and provide an adequate skilled nursing assessment resulted in patient hospitalization as follows.</p> <p>During the skilled nursing visit completed on 11/26/08, at 9:25 am the skilled nurse failed to perform an adequate assessment of the patient. Specifically, the skilled nurse documented the following:</p> <ul style="list-style-type: none"> <li>- weight 130 pounds - representative of a 6 pound weight loss in 6 days. The nurse failed to assess the patient's appetite, food and/or fluid intake or signs and symptoms of dehydration such as skin turgor or dry lips.</li> <li>- respiratory assessment included an assessment of breath sounds of rhonchi right and left - the nurse failed to document if the assessment includes all lung fields. The skilled nurse documented that the patient "denies shortness of breath" however, failed to assess the patient's respiratory status on exertion.</li> <li>- assessment the caregivers ability to provide care for the patient following the initial caregiver assessment which states that the caregiver is overwhelmed.</li> </ul> <p>At 06:42 am on 11/27/08, the patient's condition deteriorated to the point that the patient's wife contacted the on-call nurse who made a home visit and documented the following assessment resulting in the patient's hospitalization:</p> <ul style="list-style-type: none"> <li>- elevated heart rate of 112 and a rapid</li> </ul>	G 172		

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G 172	<p>Continued From page 72</p> <p>respiratory rate of 40 with exertion</p> <ul style="list-style-type: none"> <li>- shortness of breath with minimal exertion</li> <li>- thick yellow sputum from a productive cough</li> <li>- that the patient's lips were dry, cracked and his mouth was dry</li> <li>- poor skin turgor, patient not drinking adequately</li> </ul> <p>Based on this assessment the patient was sent to the emergency room. A review of the hospital admission record confirmed that the patient was admitted with shortness of breath and wheezes and crackles throughout his lung fields, and that these symptoms began 2 to 3 days earlier.</p> <p>The patient was discharged from the hospital on 12/19/08 with a new diagnosis of aspiration pneumonia requiring a percutaneous endoscopic gastric (PEG) tube for enteral feeding and blood sugar testing.</p> <p>On 12/20/08, the skilled nurse visited the patient, however failed to provide an adequate assessment of the patient post hospitalization. Specifically:</p> <ul style="list-style-type: none"> <li>- the skilled nurse documented that the patient has a PEG tube there is no assessment of the skin at the insertion site of the PEG tube or the interventions to clean the PEG tube insertion site.</li> <li>- the skilled nurse failed to assess who would perform blood sugar testing. Specifically, the skilled nurse documented that the patient's blood sugar should be tested twice a day, however, the patient could not test his blood sugars and the patient's wife refused.</li> <li>- the skilled nurse documented that the patient's medications are administered by the spouse via</li> </ul>	G 172			

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G 172	<p>Continued From page 73</p> <p>the PEG tube however, there is no evidence of medication review to ensure that all of the patient's medications can be administered through the PEG tube, that the patient's wife was observed administering the medications or flushing the PEG tube.</p> <p>This record was reviewed with the acting Administrator and the Supervising Nurses on 02/03/08. The Supervising Nurses were unaware that the assessment and subsequent plan of care were incomplete.</p> <p>3. Patient #37 was admitted to the agency on 11/06/08 with a primary diagnosis of congestive heart failure and secondary diagnoses of type II diabetes and hypertension. The patient resided in an adult home where she received 24 hour supervision and assistance with medications. The plan of care includes: skilled nursing visits twice a week the first week; 3 times a week for 1 week 2 times a week for 2 weeks then 1 time a week for 5 weeks to assess cardiovascular status every visit, including VS (vital signs) and edema measurements. The plan of care also included a Physical Therapy evaluation.</p> <p>The skilled nurse documented changes in the patient's condition between 11/06/08 and 01/02/09 including reports of chest pain, medication changes, and weight fluctuations related to fluid retention. Despite these significant changes in condition, the skilled nurse made a decision to discharge this medically unstable patient from the agency and the patient expired 8 days later.</p> <p>The following documentation is evidence of the skilled nurse's failure to recognize and assess</p>	G 172			

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G 172	<p>Continued From page 74</p> <p>changes in the patient's condition during skilled nursing visits.</p> <p>On 11/18/08, the skilled nurse documented that the patient had an increase in lower extremity edema and that she left a message at the physician's office to report this. There is no evidence of a response received from the physician's office and a no subsequent skilled nursing visit was planned or completed until 8 days later on 11/26/08.</p> <p>During the skilled nursing assessment visit on 11/26/08, the skilled nurse failed to assess the patient's weight, edema and current medications. The surveyor reviewed the adult home case management notes dated 11/24/08, which stated that the physician had ordered an extra diuretic (Lasix) to be given for 3 days. There is no evidence that the skilled nurse assessed the patient's medication regimen, and identified this change in the patient's medication.</p> <p>The next skilled nursing visit, was conducted on 11/28/08. The skilled nurse noted a weight gain of 9 pounds and significant increases in the leg measurements. Again the skilled nurse documented that she notified the physician of the patient's increased weight however, there was no follow-up by the RN until 5 days later on 12/03/08 and no response from the physician was noted.</p> <p>On 12/03/08, the skilled nurse visited the patient and documented that the patient complained of urinary frequency and left shoulder pain. There is no evidence that this was reported to the physician and no follow-up of the patient's symptoms during the next skilled nursing visit 7 days later on 12/10/08.</p>	G 172		

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G 172	<p>Continued From page 75</p> <p>On 12/10/08, the skilled nurse visited the patient and failed to adequately assess the patient's urinary symptoms which were documented during the 12/03/08 visit. The skilled nurse also failed to review the patient's medications and identify that the patient was started on an antibiotic for symptoms of a urinary tract infection on 12/04/08. This information was documented in a case management note written by Adult Home staff and dated 12/04/08.</p> <p>On 12/10, 12, 17, 21 /08, the skilled nurse visited the patient and documented changes in the patient's condition including increased weights and edema measurements requiring the addition of diuretics.</p> <p>Additionally, during the 12/24/08 the skilled nursing visit, the skilled nurse documented patient complaints of chest pain radiating down the left arm 2 days earlier. There was no subsequent assessment of the patient until 9 days later on 01/02/09.</p> <p>On 01/02/09 the skilled nurse visited the patient and failed to assess the following, which had previously been identified as patient problems:</p> <ul style="list-style-type: none"> <li>- an edema measurement</li> <li>- a weight measurement</li> <li>- symptoms of chest pain</li> <li>- a review of the patient's medications and changes that have occurred prior to discharge.</li> </ul> <p>The skilled nurse discharged the patient without assessing if the patient was stable and failed to discuss the patient's discharge with the physician and or the Adult Home staff. A review of the</p>	G 172			

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G 172	Continued From page 77 Additionally, the skilled nurse failed to assess the following:  - skin integrity. Specifically, during the initial nursing assessment dated 11/29/08, the skilled nurse documented that the patient had 6 wounds: two wounds located on the left stump and 4 wounds located on the right lower extremity including the shin, ankle and foot. During 6 skilled nursing visits completed between 12/03/08 and 1/06/09 there is no assessment of the 4 wounds located on the right lower extremity.  - edema of the right lower extremity. The initial nursing assessment indicates that the patient has a history of right lower extremity edema, during skilled nursing visits completed between 12/03/08 to 01/06/09, there is no assessment of the patients right lower extremity edema.  This record was reviewed with the acting Administrator and the Supervising Nurses on 02/04/09. No further information was provided.	G 172		
G 242	484.52 EVALUATION OF THE AGENCY'S PROGRAM  This CONDITION is not met as evidenced by: The agency failed to implement a program which identifies and resolves problems associated with quality patient care. The 06/03/2008 Annual Program Evaluation for 2007 is not of sufficient scope to identify problem areas in patient care and develop mechanisms for resolutions. Specifically, the Annual Program Evaluation failed to ensure and evaluate the following:  o The appropriateness, effectiveness, and	G 242  <i>5/15/09 acceptable</i>	The 2008 annual program evaluation will be completed by members of the governing body the AVP of Regulatory Affairs, the VP of Clinical Operations and the Administrator. This will be reflected in the minutes of the first quarter 2009 PAC meeting which will be held May 19th.	<i>5/19/09</i>

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G 242	Continued From page 78 adequacy of agency policies and procedures. G153  o The adequacy of nursing supervision and supervision of paraprofessional staff. G140  o Qualifications and training for skilled nursing staff G140  o The effectiveness of case management and physician notification/consultation. G143,144  o The accuracy and completeness of patient assessments and reassessments G171  o The agency's ability to develop and implement plans of care which address each patient's needs and assist the patient in reaching established goals G158, 159  o Quality of patient care G250  The cumulative effect of these systemic problems related to the agency's annual evaluation resulted in the home care agency's inability to ensure the provision of quality care and a negative outcome for seven patients: # 1, 2, 6, 26, 27, 30, 37 and the potential for negative outcomes for the agency's entire patient population.	G 242	See gtag 140  See gtag 143, 144  See gtag 158, 159	
G 245	484.52 EVALUATION OF THE AGENCY'S PROGRAM  The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient.	G 245	See gtag 122	

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G 245	<p>Continued From page 79</p> <p>This STANDARD is not met as evidenced by: Based on a review of: the agency's 06/03/08 Annual Program Evaluation for 2007, Professional Advisory Committee meeting minutes for 2008, and trended data reports from quarterly clinical record reviews for 2007 and 2008, evidence is lacking the Annual Evaluation is of sufficient scope to determine the extent that the agency's services and policies are appropriate, adequate, effective, and efficient.</p> <p>Evidence is lacking the Annual Program Evaluation for 2007 included a review of trended data and identified specific areas in need of improvement. Despite the fact that the agency was cited by the New York State Department of Health at Condition level deficiencies, including a determination of Immediate Jeopardy, during the 1st quarter of 2007; the report, which is documented on a Gentiva corporate form, states services are appropriate, adequate, effective and efficient, and further states under each section "recommendations None". Page 9 of the Annual Evaluation reads as follows: "After a New York State Department of Health Certified Agency survey in the 1st quarter 2007 which found this location out of compliance with 4 Conditions of Participation, referrals were slowed down in order to meet the Plan of correction requirements and staffing needs. We need to slowly and carefully build up trained staff to meet the needs of the patients and the agency". Page 12 states " 1295 + 100% Start of Care and 80% ongoing charts were audited until 7/07". There is no evidence that the results of these audits were reviewed or discussed to identify areas in need of improvement or that a focused action plan was developed to resolve specific problem areas. There is no basis on, or process by, which the</p>	G 245			



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G 245	Continued From page 80 committee made a determination regarding the adequacy, effectiveness, efficiency and appropriateness of agency services and policies.  Failure of the agency's annual evaluation to accurately determine the extent that the program is appropriate, adequate, effective and efficient has resulted in negative outcomes for seven patients: # 1, 2, 6, 26, 27, 30, 37 and has the potential for agency wide unmet patient needs and negative patient outcomes.	G 245	Policy review will be done quarterly as evidenced on the minutes of the quarterly PAC meeting minutes.		
G 248	484.52(a) POLICY AND ADMINISTRATIVE REVIEW  As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient.	G 248	Team audit process: 100% As part of the quarterly comprehensive record audit each month 20% of that team's census will be reviewed by a MCP/designee. The team's audit scores will be reviewed at the monthly record review meeting and recommendations for improving areas below benchmark will be discussed. The MCP is on the committee and has the accountability that her teams audit scores and documentation is compliant.		
G 250	This STANDARD is not met as evidenced by: See G 245 484.52(b) CLINICAL RECORD REVIEW  At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.  This STANDARD is not met as evidenced by: Based on a review of the agency's Quality Improvement Program, Professional Advisory Committee (PAC) meeting minutes, Governing Body meeting minutes and interviews with the	G 250 <i>5/15/09 acceptable</i> <i>Paula J. Williams RN HHS-C</i>	Peer review process: The MCP/designee on each team will assign 2 charts to be reviewed each quarter by each RN/PT. The outcome of the peer reviews (part of the comprehensive chart audits and integrated into that statistic) will be discussed at the monthly team meetings.  Each monthly statistics are compiled into the quarterly statistic presented at the quarterly PAC meetings.  The Administrator/DPS is responsible for audits to be completed and documentation shows compliance.		

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G 250	<p>Continued From page 81</p> <p>Agency acting Administrator and acting Director of Clinical Services (DOCS/DPS), evidence is lacking the agency's Quality Improvement program identified and corrected recurring systemic agency problems. Specifically:</p> <ul style="list-style-type: none"> <li>- There is no evidence clinicians representing all services provided by the agency have been participating in the record review process. An interview on 02/05/09 with the employee functioning as the Quality Improvement Specialist until 02/04/09, confirmed that the monthly record audits were performed by the clinical managers/supervisors. She stated that the agency will begin integrating therapy and social work staff into the process. She also stated the managers develop an action plan and present it to the PAC committee quarterly.</li> <li>- There is no evidence that monthly clinical record audits include both open and closed clinical records. A review of the audit tool and the trending graphs in use during all quarters in 2008 lack evidence of an audit of discharged records.</li> <li>- Evidence is lacking that the audit tool currently in use evaluates quality issues with respect to comprehensive assessment and case management. The tool evaluates the presence or absence of forms.</li> <li>- Evidence is lacking that the agency is developing an action plan to address and resolve identified areas in need of improvement and that the action plan is reviewed and revised quarterly based upon the agency's response. Specifically, quarterly trending reports identify percentages of</li> </ul>	G 250	<p>In addition two Gentiva auditors are here assisting with the audits and working with the MCP and clinical staff on documentation improvements. As part of this review the auditors will provide an educational in-service to the MCP staff in how to audit the clinical record. This will be completed the week of May 18, 2009.</p> <p>The Rehab Directors are reviewing 10% of the therapy charts and working with the therapy staff on their documentation.</p> <p>The Gentiva audit tool is used and entered in UNITY. Reports are run with the trend and outcomes of where we need improvement and drives the action plans.</p> <p>5 orientation charts are being audited by the MCP staff for each one of their new clinical staff. Feedback will then be provided to the clinician and the educator on any trends or patterns discovered.</p> <p>All of the above clinical record audits are a part of the 20% comprehensive quarterly chart reviews, just broken out and used monthly as appropriate to be identifying and correcting documentation issues on an ongoing basis.</p> <p>The RC2 is auditing 10 personnel files per quarter, this will include performance evals and supervisory visits.</p>		<p>5/4/09 to 5/22/09</p>

5/15/09 accept tabb  
Paula Phillips

(The Gentiva auditors work daily with the MCP staff and the clinical staff to

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G 250	Continued From page 82 completion for quality indicators based on monthly clinical record audits. The 3rd quarter trending report identified 67% compliance in the area of "clinical notes show evidence of following the plan of care", 75% compliance "complete wound assessment". The 4th quarter trending report identified 47% compliance in the area of "clinical notes show evidence of following the plan of care, 67% compliance "complete wound assessment".  There is no evidence the agency's Quality Improvement program: identified the decreased compliance in both areas: reviewed the previous quarter action plan to determine why improvement did not occur; or develop a specific action plan to resolve the problems. Action plans are general and include inservice education and case conferences with supervisors, however there is no mechanism in place to review and revise these plans.  There is no evidence in any of the Professional Advisory meeting minutes for all quarters in 2008 that action plans from the previous quarter are being reviewed and revised based on new trended data.	G 250	Complaints, infections and incidents are discussed at the morning meetings and also trended for PAC quarterly  Dr. Bishop will be reviewing with the PAC meeting a patient who had a potential negative outcome with the PAC committee.  Dr. Bishop will be providing in-services on geriatric care. She is also available to give a physician perspective on difficult to serve patients as needed to the branch.  Through monthly team meetings, medical record committee meetings and the Administrator/DPS meeting with the MCP staff, the focus will remain on compliant documentation. This will be monitored through the above audits listed below. The areas being monitored through PAC are:	5/19/09
G 337	484.55(c) DRUG REGIMEN REVIEW  The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.  This STANDARD is not met as evidenced by: In 13 of 13 observational home visits (100%)	G 337	<ul style="list-style-type: none"> <li>• Chart audit results</li> <li>• Orientation chart audit results</li> <li>• Personnel files and skill checklists</li> </ul>	

acceptable  
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G 337	<p>Continued From page 83</p> <p>conducted by the surveyor with the skilled nurse, and interviews with agency staff, the acting Administrator and Supervising Nurses, evidence is lacking that the skilled nurse is assessing the patient's current medication regime and maintaining an accurate medication list as outlined in the agency's policy manual.</p> <p>Specifically, the agency's policy labeled "3-5 Assessment - Review of patients' medications" states that the patient's medications will be reviewed during the initial assessment and each subsequent assessment. The review will include viewing the bottles and labels of drugs the patient has.</p> <p>Patient # 1, 2, 4, 6, 7, 8, 9, 14, 16, 17, 19, 21, 28, 30, 37.</p> <p>Failure to ensure complete and accurate medication reviews by the skilled nurse has the potential for unmet patient needs and the potential for negative outcomes.</p> <p>Examples are as follows:</p> <p>Home Visit</p> <p>1. Patient # 9 was admitted to the agency on 11/28/08 with a primary diagnosis of end stage renal disease and a history of peripheral vascular disease, status post kidney transplant, an esophageal biopsy, and insertion of a jejunostomy feeding tube. Evidence is lacking that the skilled nurse provided an adequate assessment of the patient's current medications as specified in the agency's policy manual.</p> <p>Specifically, an observational home visit was conducted on 01/23/09 by the surveyor with the</p>	G 337	<ul style="list-style-type: none"> <li>• RN case management case loads</li> <li>• Review of the quarterly policy updates and revisions sent out each quarter. This will ensure all policies are reviewed annually</li> <li>• Incidents, complaints and infection trends</li> <li>• Adverse events</li> <li>• 100% SOC/POT reviews to ensure accurate assessments and holistic POT are being completed by the MCP staff</li> </ul> <p>The governing body will participate in PAC with the attendance via conference call or in person of the AVP of Regulatory Affairs.</p> <p>Policy review will be done quarterly as evidenced on the minutes of the quarterly PAC meeting minutes.</p> <p>As part of the initial assessment visit and in subsequent visits the clinician will ask the patient and will review the prescription bottles for any changes in medications. Changes will be incorporated into the medication profile and a case communication sent to the MD.</p> <p>This will be audited as part of the comprehensive chart audit.</p>		

5/15/09 Acceptable Paulaf Williams PA

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G 337	<p>Continued From page 84</p> <p>skilled nurse at 3 pm. The skilled nurse conducted a re-certification visit. During the visit, the surveyor observed the skilled nurse rewriting the patient's medication list dated 12/30/08. The skilled nurse failed to look at the patient's medication bottles or review the specific medications the patient was taking with the caregiver as outlined in the agency's policy. During the visit, the surveyor asked the skilled nurse why she was recopying the medication list? The skilled nurse stated that it was the agency's policy to "recopy the medication list with recertification". The skilled nurse was unaware that the agency policy included a review of the medication bottles. As a result, the following medication discrepancies were found during clinical record review:</p> <ul style="list-style-type: none"> <li>- the medication list contained an antidepressant medication, Remeron, however, this medication was not included on the plan of care.</li> <li>- both the medication list and the plan of care stated that the patient's two new medications Lasix (diuretic) and Cipro (antibiotic) were ordered to be taken orally, however, the plan of care dated 11/28/09 documents the patient is not to take anything by mouth.</li> </ul> <p>This record was reviewed with the acting Administrator and the Supervising Nurses on 02/10/09. No additional information was provided.</p> <p>Home Visit</p> <p>2. Patient # 16 was admitted to the agency on 11/06/08 with a primary diagnosis of a non-healing surgical wound, and a history of</p>	G 337		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>337255</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/15/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>GENTIVA HEALTH SERVICES LIVERPOOL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 ELWOOD DAVIS ROAD</b> <b>LIVERPOOL, NY 13088</b>		
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G 337	<p>Continued From page 85</p> <p>insulin dependent diabetes, hypertension and diabetic retinopathy resulting in the patient's limited vision. Evidence is lacking that skilled nurse reviewed medications during visits to ensure that all personnel were aware of the patient's current medication regimen.</p> <p>Specifically, the plan of care stated that the patient requires skilled nursing visits 3 times a week for wound care and ensuring that the patient has prefilled insulin syringes.</p> <p>The RN failed to review the patient's medications during an observational home visit conducted by the surveyor with the skilled nurse at 08:30 am on 01/28/09. At the conclusion of the observational home visit, the surveyor reviewed the medications with the patient and identified the following discrepancies with the medication list which was last updated by the skilled nurse on 01/02/09:</p> <ul style="list-style-type: none"> <li>- the medication list included the following medications that the patient stated that he was no longer taking: Plavix (used to prevent the formation of blood clots) or Percocet for pain.</li> <li>- the medication list failed to include Tylenol Arthritis for pain and hydrocortisone cream to dry itchy skin which the patient stated he was applying.</li> <li>- the medication list states that the patient takes Aleve 200 mg by mouth as needed for pain, the patient stated that he takes this medication twice a day every day not just as needed for pain.</li> </ul> <p>This information was reviewed with the acting Administrator and the Supervising Nurses on</p>	G 337			

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NAME OF PROVIDER OR SUPPLIER

GENTIVA HEALTH SERVICES LIVERPOOL

STREET ADDRESS, CITY, STATE, ZIP CODE

200 ELWOOD DAVIS ROAD  
LIVERPOOL, NY 13088

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G 337	<p>Continued From page 86</p> <p>02/03/09. No further information was reviewed.</p> <p>Home Visit</p> <p>3. Patient # 21 was admitted to the agency on 01/27/08 with a primary diagnosis of insulin dependent diabetes and a history of diabetic retinopathy, therapeutic drug monitoring, hypertension and long term use of insulin. Evidence is lacking that the skilled nurse is reviewing medications and updating the medication list and plan of care as follows:</p> <p>An observational home visit was conducted by the surveyor on 02/05/09 at 3:30 pm with the skilled nurse. During the visit, the surveyor observed the skilled nurse administering eye drops to both eyes, the surveyor reviewed the medication list which did not include eye drops. Additionally, there was no documentation that the skilled nurse had been administering these eye drops during twice daily visits.</p> <p>This record was reviewed with the acting Administrator and the Supervising Nurses on 02/09/09. No further information was provided.</p>	G 337		

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NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS - SYRACUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 EAST FAYETTE STREET SYRACUSE, NY 13210
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H 000

Initial Comments

This Statement of Deficiencies report is the result of an Article 36 full survey and complaint investigation (Complaint #09-03-30001) conducted on March 4-5, 2009. The survey consisted of a review of six (6) patient records (#1-6), including one (1) discharged record, two (2) patient home visits, seven (7) personnel records of professional and para-professional staff (Employees A-G), the agency's Quality Assurance meeting minutes for the past 12 months, complaint log, Health Provider Network account, policies and procedures, and interviews with the Director of Clinical Services and General Manager.

H 000

Poc accepted 5/19/09  
Melissa Galletta  
HCBS Surveyor

H 404

766.3(b) Plan of care

766.3 Plan of care.

The governing authority or operator shall ensure that:

.....  
(b) a plan of care is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential.

This Regulation is not met as evidenced by:  
Based on review of six (6) patient records and interview with the Director of Clinical Services, evidence is lacking in 6 records that a complete plan of care is developed based on the nursing assessment. (Patients #1-6)

Failure to develop a plan of care which includes pertinent diagnosis, prognosis, mental status, frequency of each service to be provided,

H404

A plan of care will be established for each client based on a professional assessment of the client's needs and will include pertinent diagnoses, prognosis, mental status, frequency of each service to be provided, medications, treatments, diet, functional limitations, prognosis. To ensure that the plan of care is inclusive of all necessary information, the client care assessment has been revised as well as the Medical Orders. 100% of clients being admitted into the agency will be reviewed by the RN DCS to ensure all needs are being captured. Additionally, 100% of the existing client population will be reviewed and any additional information will be provided to the MD on a supplemental order form. Completion date for review of all charts and return of any additional orders will be 6/30/09.

4/1/09

Office of Health Systems Management / Office of Long Term Care

TITLE

(X6) DATE

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

Version 09/12/08

6699

XWID11

If continuation sheet 1 of 19



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H 404	<p>Continued From page 1</p> <p>medications, treatments, diet regimens, functional limitations and rehabilitation potential may lead to unmet patient needs and negative patient outcomes.</p> <p>Examples are as follows:</p> <p>1. Patient # 1 is a [REDACTED] admitted to the agency on 2/17/09 with a primary diagnosis of dementia, and secondary diagnoses of arthritis, hypertension, congestive heart failure (CHF), and gastro-esophageal reflux disorder. The nursing assessment dated 2/18/09 identified the following information about the patient: diagnoses of macular degeneration, aphasia, edema of bilateral lower extremities, incontinence, a history of stroke in 2006, use of a Lidoderm patch for pain management, and a no salt diet. None of this information was included in the patient's plan of care. Additionally, there was no further assessment or treatment plan of the edema. The nursing assessment also identified that the patient was incontinent, used Depends, and had nocturia. The plan of care failed to identify the level of assistance that the patient required for toileting and use of Depends. The nursing assessment failed to include an assessment of the patient's self-medication ability. The plan of care also failed to identify this, and who was responsible for administering medications.</p> <p>This was reviewed with the Director of Clinical Services on 3/5/09. No further evidence was provided.</p> <p>2. Patient #3 is a [REDACTED] admitted to the agency 9/19/08 with a primary diagnosis of dementia, and secondary diagnoses of hearing and vision loss. The nursing assessment completed 9/19/08 identified that the patient had</p>	H 404	<p>Additionally, the QA committee will meet quarterly and review 20% of client charts to ensure Compliance.</p> <p><i>Acceptable 5/19/09</i> <i>MTG</i></p>		

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H 404	<p>Continued From page 2</p> <p>macular degeneration, edema of the ankles, bowel and bladder incontinence, and nocturia. These diagnoses were lacking in the patient's plan of care. Additionally, the plan of care lacked the patient's prognosis, mental status, and frequency of home health aide services.</p> <p>This was reviewed with the Director of Clinical Services on 3/5/09. No further evidence was provided.</p> <p>3. Patient #6 is an [REDACTED] admitted to the agency on 1/6/09 with diagnoses of hypertension, anemia, and constipation. The nursing assessment dated 1/6/09 identified patient diagnoses of bilateral edema of feet, generalized weakness, urinary incontinence, and broken left hip 10/10/08 as a result of a fall. These diagnoses were not included in the patient's plan of care. The assessment also identified the following information: the patient was forgetful, had poor eyesight, problems with gait/balance, required assistance with transfers, (the level of assistance was not specified), and the patient was unable to remain unsupervised. This information was lacking in the plan of care. Additionally, the plan of care lacked the patient's prognosis and mental status.</p> <p>A negative outcome was identified when this patient fell and hit her head on 2/3/09, while under the supervision of an agency Home Health Aide. The patient required hospitalization and subsequent placement in a skilled nursing facility.</p> <p>This was reviewed with the Director of Clinical Services on 3/5/09. No further evidence was provided.</p>	H 404			

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H 514 H 514	<p>Continued From page 3</p> <p>766.4(d) Medical orders</p> <p>766.4 Medical orders.</p> <p>.....</p> <p>(d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, and other pertinent patient information relevant to the agency plan of care; and</p> <p>(1) shall be authenticated by an authorized practitioner within thirty (30) days after admission to the agency; and</p> <p>(2) when changes in the patient's medical orders are indicated, orders, including telephone orders, shall be authenticated by the authorized practitioner within thirty (30) days.</p> <p>This Regulation is not met as evidenced by: Based on review of six (6) patient records, and interview with the Director of Clinical Services (DCS), evidence is lacking in 6 records that the medical orders were complete and referenced all diagnoses, medications, treatments, prognoses, and other pertinent information. (Patients #1-6) Additionally, evidence is lacking in 3 records that medical orders were authenticated by a physician within 30 days of admission; or when a change in care was indicated. (Patients #4, 5, 6)</p> <p>Failure to maintain complete medical orders may lead to unmet patient needs and/or negative patient outcomes.</p> <p>Examples are as follows:</p> <p>1. Patient #4 is [REDACTED] admitted to the agency on 2/5/09 with diagnoses of arthritis, glaucoma, hypertension, dysrhythmia, incontinence, and BPH. The medical orders dated 2/5/09, and signed by the physician on</p>	H514	<p>Client medical orders will reference all diagnoses, medications, treatments, and other pertinent client information relevant to the agency plan of care. All medical orders will be authenticated by the authorized practitioner within 30 days. The medical orders have been revised to include the following information: (See attachment B)</p> <ul style="list-style-type: none"> <li>-diet</li> <li>-functional limitations/assistive devices</li> <li>-mental status</li> <li>-medication assistance required</li> <li>-frequency of service required</li> <li>-certification period</li> </ul> <p>The RN will complete the medical orders after performing the initial assessment. Before the orders are sent to the practitioner, they will be reviewed by the DCS for accuracy and completion. The orders will then be sent to the practitioner and placed in the client's chart. The fax cover sheet is then placed in a "pending" file in the DCS's office. When the orders are returned to the office, the fax cover sheet is removed from the file. The signed orders are then placed in the client's chart, removing the original unsigned orders.</p>		

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H 514	<p>Continued From page 4</p> <p>2/10/09, stated that the patient was receiving 24-hour home health aide care. Per an interview with the DCS and General Manager on 3/5/09, the patient received 24-hour live-in care from 2/5/09- 2/12/09. As of 2/16/09, the patient received HHA service 5 days per week from 9 PM- 12 PM the following day. The medical orders were not updated to reflect this change in the patient's level of care. Additionally, the medical orders lacked other pertinent diagnoses, including congestive heart failure and basal cell carcinoma.</p> <p>This was reviewed with the DCS and General Manager (GM) on 3/5/09. No further evidence was provided.</p> <p>2. Patient #5 is an [REDACTED] admitted to the agency on 1/30/09 with a primary diagnosis of Chronic Obstructive Pulmonary Disease (COPD), and secondary diagnoses of Coronary Artery Disease (CAD), myocardial infarction, prostratitis, hematuria, and Deep Vein Thrombosis (DVT), left lower extremity.</p> <p>The patient was originally admitted to the agency and assessed by the RN on 12/23/08. A care plan was developed 12/23/08, and home health aide care was initiated on 12/24/08. Evidence supports that medical orders were sent to the physician on 12/29/08, however, were never returned with the physician's signature. The patient was discharged on 12/29/08 due to a hospitalization, and a discharge summary was subsequently sent to the physician. Once the patient returned home from rehabilitation, he was re-admitted to the agency, and the RN completed a new assessment on 1/30/09. However, the agency failed to obtain new medical orders or complete a new plan of care as of 1/30/09.</p>	H514 cont'd	<p>The file is checked on a weekly basis by both the DCS and the RN case manager. Any outstanding orders are resent. If after the 2<sup>nd</sup> attempt the orders are not returned, the DCS or RN case manager will call the provider to alert them to a potential problem. the orders will continue to be sent until they are returned with a signature. The DCS will be ultimately responsible to ensure all medical orders are returned within the 30 day time period. Additionally, any changes in the client's medical orders will be authenticated by the provider within 30 days. Any necessary changes will be placed on a "supplemental" order form and sent to the practitioner. (See attachment C) These changes may include diagnoses, treatments, prognosis, service required, etc. These orders will also monitored by the DCS and RN case manager. The same procedure will be used as with the original medical orders.</p>

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H 514	Continued From page 5  Additionally, the medical orders lacked all pertinent patient information, including all diagnoses (hypertension, edema, and dementia), frequency of services ordered (Home Health Aide 7 days/week, 1 hour/day), treatments (care of Foley catheter), and prognosis.  This was reviewed with the DCS and GM on 3/5/09. No further evidence was provided.  3. Patient #6 is an [REDACTED] admitted to the agency on 1/6/09 with diagnoses of hypertension, anemia, and constipation. The medical orders were dated 1/6/09 and signed by the physician on 2/10/09, not within 30 days. Additionally, the medical orders failed to include all pertinent diagnoses (edema, generalized weakness, urinary incontinence, and broken left hip 10/10/08).  This was reviewed with the DCS and GM on 3/5/09. No further evidence was provided.	H514 cont'd	The orders will also continue to be sent out until they are signed. Any supplemental orders that are not signed after the 2 <sup>nd</sup> attempt will be followed with a phone call to the provider's office to alert them to a potential problem.  In addition, any client that is hospitalized and is then subsequently discharged from the agency, will receive a new assessment generating a new plan of care and a new set of medical orders. The same procedure will be followed to ensure the new medical orders are then authenticated by the provider within the 30 day time period. The DCS will be responsible to closely monitor compliance to this procedure.		
H 614	766.5(b)(1) Clinical supervision  766.5 Clinical supervision. The governing authority shall ensure for all health care services that:  ..... (b) all staff delivering care in patient homes are adequately supervised. The department shall consider the following factors as evidence of adequate supervision:  (1) staff regularly provide services at the times and frequencies specified in the patient's plan of care and in accordance with the policies and procedures of their respective services. This Regulation is not met as evidenced by:			4/1/09	



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H 614	<p>Continued From page 6</p> <p>Based on review of six (6) patient records, 2 patient home visits, and interview with the Director of Clinical Services, evidence is lacking in 6 records that staff provided services at the times and frequencies specified in the patient's plan of care. (Patients #1-6)</p> <p>Failure to provide adequate supervision may lead to unmet patient needs and/or negative outcomes.</p> <p>Examples are as follows:</p> <p>1. Patient #6 is an [REDACTED] admitted to the agency on 1/8/09 with diagnoses of hypertension, anemia, and constipation. The patient received 24-hour home health aide services to assist with the following personal care: shower, denture care, shampoo, dressing, nail care, transfer, toileting, meal preparation, and encouraging fluids. Based on review of home health aide documentation from 1/6/09- 2/4/09, a total of 30 days, evidence is lacking for the following:</p> <ul style="list-style-type: none"> <li>-That nail care was provided at any visits.</li> <li>-Transfer assistance was provided on 17 days.</li> <li>-Assistance with shampooing was provided on 13 days.</li> <li>-Meal preparation and encouraging fluids was provided on 9 days.</li> <li>-A shower was provided on 5 days.</li> <li>-Toileting, assistance dressing, and denture care was provided on 4 days.</li> </ul> <p>Additionally, evidence was found of personal care provided that was not on the care plan, including documentation of performing passive range of motion, changing protective briefs, medication reminders, and feeding.</p>	H 614	<p>100% of all new admissions will be reviewed by the RNDCS to ensure all pertinent information is included on the MD order form. 100% of the existing client population will be reviewed and any additional information will be added to a supplemental order form and sent to the MD for approval. Completion date for review of all client charts and return of supplemental orders is 6/30/09. The QA committee will review the process quarterly by auditing 20% of client charts.</p> <p>Since the time of the initial audit, client #5's MD orders were resent to his original physician who provided care prior to his move to this area. The MD was very familiar with the client and was comfortable dating the orders to cover the time period for which service was provided. A second set of MD orders was then also sent to his new MD after he was released from the hospital. The new orders reflect the clients medical condition accurately. Client #4 and #6 have since been discharged from the agency and no further orders were obtained.</p> <p><i>Acceptable 5/19/09 MAG</i></p>		

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H 614	<p>Continued From page 7</p> <p>This record was reviewed with the Director of Clinical Services and General Manager on 3/5/09. No further evidence was provided.</p> <p>2. Patient #1 is a [REDACTED] admitted to the agency on 2/17/09 with a primary diagnosis of dementia, and secondary diagnoses of arthritis, hypertension, congestive heart failure, and gastro-esophageal reflux disorder. The patient was receiving 24-hour care for assistance with the following personal care tasks: shower, oral care, shampoo, dressing, positioning every 2 hours, "hands-on" transfer assistance, encourage fluids, meal preparation/feeding, toileting, and skin care. Based on review of home health aide documentation from 2/18/09- 3/2/09, a total of 13 days, evidence is lacking for the following:</p> <ul style="list-style-type: none"> <li>-That a home health aide provided care on 2/27/09.</li> <li>-Skin care was provided at any visits.</li> <li>-Positioning every 2 hours was completed on 8 days.</li> <li>-Shampoo was provided on 7 days.</li> <li>-A shower was provided on 3 days.</li> <li>-Assistance with oral care, transfers and dressing was provided on 2 days.</li> </ul> <p>Additionally, evidence was found of personal care provided that was not on the care plan, including documentation of performing passive range of motion, changing protective briefs, combing hair, grooming, and shaving.</p> <p>This record was reviewed with the Director of Clinical Services and General Manager on 3/5/09. No further evidence was provided.</p> <p>3. Patient #5 is an [REDACTED] admitted to</p>	H 614	<p>All staff delivering care in a client's home will receive adequate supervision. The DCS and RN case manager will ensure that each employee that is providing service is properly oriented to the specific tasks to be completed and that these tasks are reflected accurately on the flow sheet. 100% of all flow sheets will be reviewed weekly by the RNDCS to ensure compliance with the client's plan of care. If an aide fails to provide services as documented on the plan of care or provides additional services not authorized, the aide will receive additional training and counseling. If the aide again deviates from the care plan, disciplinary action will be taken up to and including termination. Weekly tracking forms will be maintained by the scheduling coordinators for use in tracking any orientation that need to take place. These forms will be reviewed each Friday by the RNDCS. The QA committee will also review the results of these forms on a quarterly basis.</p>		5/1/09

Acceptable  
5/19/09 MG

## New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  LC0362A	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/05/2009
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NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS - SYRACUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 EAST FAYETTE STREET SYRACUSE, NY 13210
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 614	<p>Continued From page 8 the agency on 1/30/09 with a primary diagnosis of Chronic Obstructive Pulmonary Disease (COPD), and secondary diagnoses of Coronary Artery Disease (CAD), myocardial infarction, prostratitis, hematuria, and Deep Vein Thrombosis (DVT), left lower extremity. The patient was receiving shared home health aide service for 1 hour per day, 7 days per week, to assist with a shower every other day, and daily oral care, dressing, empty catheter drainage bag, encourage fluids, medication reminder, and toileting as needed. Based on review of home health aide documentation from 2/2/09-3/1/09, a total of 28 visits, and interview with the patient, evidence is lacking that the home health aide provided assistance with all tasks in the care plan at each visit.</p> <p>Specifically:</p> <ul style="list-style-type: none"> <li>-Between 2/2/09 and 3/1/09, there was no documented evidence of assistance provided with oral care, toileting, emptying of drainage bag, or encouraging fluids. Per an interview with the patient on 3/5/09, the patient stated that he empties the drainage bag himself. This was not documented on the aide activity sheet.</li> <li>-Evidence was lacking for medication reminders at 23 visits. Per an interview with the patient on 3/5/09, the patient stated that he usually takes his medication before the home health aide arrives in the morning. This was not documented on the aide activity sheet.</li> <li>-Evidence was lacking for assistance with dressing at 21 visits.</li> <li>-Evidence was lacking that a shower was provided at any visit between 2/2/09 and 2/11/09, a total of 10 visits.</li> <li>-Documentation of 15 HHA visits between 2/2/09 and 3/1/09 provided evidence of only the time that the HHA provided care. The record lacked</li> </ul>	H 614		



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H 614	Continued From page 9 documentation of what specific tasks were completed.  This record was reviewed with the Director of Clinical Services and General Manager on 3/5/09. No further evidence was provided.	H624	All Home Health Aides providing In home services for client's will be properly supervised and oriented by professional staff. The DCS will be directly responsible for ensuring that all employees fully understand the plan of care for the client. When an employee is assigned to a case for the first time, the scheduling department will alert the DCS directly. The orientation will be completed by either the DCS or the RN Case Manager, as designated by the DCS. If the Home Health Aide is not familiar with any aspects of care needed to safely provide service to the client, the RN will provided in person instruction with redemonstration. If the Home Health Aide is familiar with the type of care required, the orientation can occur over the phone. Under no circumstances will the initial service visit orientation occur over the phone.	
H 624	766.5(d) Clinical supervision  766.5 Clinical supervision. The governing authority shall ensure for all health care services that: ..... (d) in-home supervision by professional staff of home health aides and personal care aides occurs:  (1) to demonstrate to and instruct the aide in the treatments or services to be provided with successful redemonstration by the aide during the initial service visit or where there is a change in personnel providing care, if the aide does not have documented training and experience in performing the tasks prescribed in the plan of care;  (2) where any of the conditions set forth in paragraph (3) of subdivision (b) of this section occur, to evaluate the condition and initiate any revision in the plan of care which may be needed; and  (3) to instruct the aide as to the observations and written reports to be made to the supervising nurse or therapist. This Regulation is not met as evidenced by: Based on review of 6 patient records, 7 personnel records, and interview with the Director of Clinical Services, evidence is lacking in 1 patient record (Patient #6) and one personnel record (Employee			

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H 624	<p>Continued From page 10</p> <p>G) that all home health aides working on this case received an appropriate orientation to the specific treatments and services required for this patient, and that the aides were capable of redemonstration.</p> <p>Failure to provide proper in-home supervision by professional staff of home health aides may result in unmet patient needs and/or negative patient outcomes.</p> <p>Specifically, aide orientation was documented in the patient record for the two home health aides who worked on this 24-hour live-in case from 1/6/09- 2/2/09. It lacked evidence of an orientation for the home health aide (Employee G) who was working with the patient (for the first time) when an incident occurred on 2/3/09. This incident was a fall that resulted in the patient sustaining a severe head injury and requiring hospitalization.</p> <p>This was reviewed with the DCS and General Manager on 3/5/09. No further evidence was provided.</p>	H624 Cont'd	<p>In addition, employees will receive a copy of and sign the orientation policy which states they understand and agree that they will not initiate any care on any client until they have been oriented by the RN. The DCS and RN case manager will review the weekly client schedule to monitor that any new aide scheduled to a case receives the proper orientation. As stated previously, a tracking sheet will be used to monitor compliance with the orientation policy. Tracking sheets will be reviewed weekly by the DCS and Quarterly by the QA committee.</p> <p><i>Acceptable</i> <i>5/19/09 MAG</i></p>	
H1020	<p>766.9(j) Governing authority</p> <p>Section 766.9 Governing authority.</p> <p>The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall:</p> <p>.....</p> <p>(j) ensure the development and implementation of a patient complaint procedure to include:</p> <p>(1) documentation of receipt, investigation and resolution of any complaint, including the maintenance of a complaint log indicating the</p>			

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H1020	<p>Continued From page 11 dates of receipt and resolution of all complaints received by the agency.</p> <p>(2) review of each complaint with a written response to all written complaints and to oral complaints, if requested by the individuals making the oral complaint:</p> <p>(i) explaining the complaint investigation findings and the decisions rendered to date by the agency within 15 days of receipt of such complaint; and</p> <p>(ii) advising the complainant of the right to appeal the outcome of the agency's complaint investigation and the appeal procedure to be followed;</p> <p>(3) an appeals process with review by a member or committee of the governing authority within 30 days of receipt of the appeal; and</p> <p>(4) notification to the patient or his or her designee that if the patient is not satisfied by the agency's response, the patient may complain to the Department of Health's Office of Health Systems Management.</p> <p>This Regulation is not met as evidenced by: Based on review of the agency's complaint log, 6 patient records, and interviews with the Director of Clinical Services and the General Manager, evidence was lacking that the agency documented, investigated, reviewed and resolved all complaints received.</p> <p>Failure to document, investigate, review and resolve all complaints received may lead to unmet patient needs and/or negative patient outcomes.</p> <p>Specifically related to the complaint identified in</p>	H1020	<p>The agency will document receipt, investigation, and resolution of all complaints voiced on behalf of any client's. A complete record will be maintained in the complaint log. A written response will be provided for each complainant outlining the investigation and the decision rendered by the agency within 15 days. The resolution will be clearly defined in the complaint log. The DCS will be directly responsible for maintaining the complaint log. The Governing Authority will review all appeals to any findings of the agency within 30 days of the appeal. All complainants will be advised that if they are not satisfied by the agency's response to a complaint, they may complain to the Dept. of Health. This information will be relayed to the complainant with the initial response. In addition, this information is provided to the client and or family upon admission to the agency.</p>	4/3/09

Acceptable 5/19/09 MAB

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H1020	Continued From page 12 this survey, evidence was lacking that the agency documented and investigated all complaints made on behalf of the patient. Evidence was also lacking of a resolution to the identified complaint, which was voiced to the agency on 2/16/09, and to the Department of Health on 3/2/09.  This was reviewed with Director of Clinical Services and the General Manager on 3/5/09. No further information was provided.	H1020			
H1036	766.9(f) Governing authority  Section 766.9 Governing authority.  The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall:  ..... (f) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided. The committee shall meet at least four times a year to:  (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption;  (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes:  (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three	H1036			

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H1036	<p>Continued From page 13 months; and</p> <p>(ii) all cases with identified patient complaints as specified in subdivision (j) of this section;</p> <p>(3) prepare and submit a written summary of review findings to the governing authority for necessary action; and .</p> <p>(4) assist the agency in maintaining liaison with other health care providers in the community. This Regulation is not met as evidenced by: Based on review of the agency's Quality Assurance meeting minutes for the past twelve months, and interview with the Director of Clinical Services and the General Manager, evidence is lacking for the following:</p> <ul style="list-style-type: none"> <li>-That the QA committee members includes a consumer.</li> <li>-That the QA committee met at least four times in the past year. Evidence was found of only two meetings in the past 12 months, dated 7/21/08 and 12/5/08.</li> <li>-That the clinical record review was conducted in a manner that reviewed the safety, adequacy, type and quality of services provided. The audit tool used revealed only the presence or absence of a document.</li> <li>-That a written summary of findings was prepared and submitted to the governing authority.</li> </ul> <p>Failure to fulfill the functions of the Quality Assurance committee may lead to unmet patient needs and negative patient outcomes.</p> <p>This was reviewed with the Director of Clinical Services and the General Manager on 3/5/09. No further evidence was provided.</p>	H1036	<p>The QA committee will meet quarterly to establish and oversee standards of care provided by the agency. The Administrator and DCS will work together to ensure these meetings take place once each quarter. The anticipated dates for these meetings are April 2009, June 2009, September 2009, December 2009, February 2010, May 2010, August 2010, and October 2010. The committee will also include a consumer. The audit tool used by the committee to review client charts has been revised to include proper completion of all forms in the client's chart. All audit tools will be reviewed by the DCS and all issues will be addressed. The audit information as well as a summary of the QA meeting will be submitted to the Governing Authority (Ian Webber) for review and approval.</p> <p><i>Acceptable 5/19/09</i> <i>MAG</i></p>		4/23/09

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H1142 H1142	Continued From page 14 766.9(o) Governing Authority  Section 766.9 Governing authority  (o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department's Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency's HPN coverage consistent with the agency's hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency's HPN accounts shall consist of, but not be limited to, the following:  (1) sufficient designation of the agency's HPN coordinator(s) to allow for HPN individual user application;  (2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health;  (3) adherence to the requirements of the HPN user contract; and  (4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly	H1142	The HPN account has been updated to include the necessary 24/7 contact information as required by the DOH. This information was updated as of 3/31/09. Additionally, an HPN policy has been developed to outline proper procedure pertaining to the account. The policy was reviewed and accepted by the QA committee. The DCS and the Administrator are directly responsible for ensuring adherence to the policy.  <i>Acceptable</i> <i>MAG 5/19/09</i>	3/31/09

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H1142	Continued From page 15 basis.  This Regulation is not met as evidenced by: Based on review of the agency's Health Provider Network (HPN) account, policies and procedures manual, and interview with the Director of Clinical Services, evidence is lacking of a complete HPN account and policy.  Specifically, the agency lacked a policy/procedure for HPN access and reporting requirements. Additionally, the agency failed to designate the 24-hour, 7-day a week contact information in the Communications Directory.  Failure to maintain a current Health Provider Network account and policy may lead to unmet patient needs in the event of an emergency.  This was reviewed with the General Manager and Director of Clinical Services on 3/5/09. No further evidence was provided.	H1142			
H1306	766.11(c) Personnel  766.11 Personnel.  The governing authority or operator shall ensure for all health care personnel: ..... (c) that the health status of all new personnel is assessed and documented prior to assuming patient care duties. The assessment shall be of sufficient scope that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics,	H1306			

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H1306	Continued From page 16 alcohol or other drugs or substances which may alter the individual's behavior. This Regulation is not met as evidenced by: Based on review of 7 employee medical records and interview with the Director of Clinical Services, evidence is lacking in 2 employee records of completion of a health status assessment prior to patient contact. (Employees C, F)  Specifically: Employee C was a Home Health Aide hired on 10/20/08. A document in the record stated that she was seen by her physician on 8/14/08 for a routine yearly exam. However, it lacked evidence that the employee was free from a health impairment or drug habitation.  Employee F was a Home Health Aide hired on 2/9/09. The employee's pre-employment physical was dated 2/13/09 but lacked evidence that the employee was free from a health impairment or drug habitation.  This was reviewed with the General Manager and DCS on 3/5/09. No further evidence was provided.	H1306	All new personnel will have an evaluation by a health care provider stating the Individual is free from health impairment which is of potential risk to a client or which might interfere with the performance of his/her duties. The statement will also verify that the individual is free from habitation or addiction to depressants, stimulants, narcotics, alcohol, or other drug or substances which may alter the individual's behavior. The evaluation will occur prior to assuming client care duties. The Human Resources Representative will be responsible for obtaining the necessary documentation prior to hiring any prospective employees. Further, before the employee attends the company orientation, the DCS will review the documentation for accuracy and completion.	3/31/09	
H1336	766.11(f)(i) Personnel  766.11 Personnel.  The governing authority or operator shall ensure for all health care personnel:  ..... (f) (i) that prior to patient contact, employment history from previous employers, if applicable, and recommendations from other persons unrelated to the applicant if not previously employed, are verified.				



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NAME OF PROVIDER OR SUPPLIER

COMFORT KEEPERS - SYRACUSE

STREET ADDRESS, CITY, STATE, ZIP CODE

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H1342	<p>Continued From page 18 responsibilities, and to the policies and procedures of the agency. (Employees B, C, F)</p> <p>Failure to provide orientation to new employees may lead to unmet patient needs and/or negative patient outcomes.</p> <p>This was reviewed with the Director of Clinical Services and General Manager on 3/5/09. No further evidence was provided.</p>	H1342	<p>All personnel will receive orientation to the agencies policies and procedures and to their specific job responsibilities. The orientation will occur prior to the employee assuming any client care duties. The orientation will be completed jointly by the Human Resources Representative and the RN. Under no circumstances will any employee provide services to a client without first being oriented to the agency. The completed orientation will be documented on the appropriate form and signed by the employee. The DCS will monitor that each new employee receives the proper orientation and that each employee chart contains verification of the orientation.</p> <p><i>Acceptable 5/19/09 MAG</i></p>	4/3/09

New York State Department of Health

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NAME OF PROVIDER OR SUPPLIER <b>GREENPOINT SENIOR LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 OLD LIVERPOOL ROAD LIVERPOOL, NY 13088</b>		
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H 000	Initial Comments  This Statement of Deficiencies report is the result of a complaint [#08-06-30014] investigation. The survey consisted of the review of 2 patient records, review of the agency's policy on the destruction of controlled medication, review of 8 personnel records, interviews with 1 part-time Home Care Registered Nurse, 1 Home Care Licensed Practical Nurse, the Administrative Assistant, the Administrator, the Enriched Housing Coordinator, 2 patient home visits, 2 Home Care Aides, and 1 phone interview with a part-time Registered Nurse.	H 000		
H 404	766.3(b) Plan of care  766.3 Plan of care.  The governing authority or operator shall ensure that: ..... (b) a plan of care is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential. This RULE: is not met as evidenced by: Based on a review of 2 patient records evidence is lacking in 2 records, 100%, that the Patient Nursing Assessments and Plans of Care included the complete functional limitation of each patient and the increased frequency of aide service needed at specific times for each patient throughout the day.  Failure to include the complete functional limitations and the need for increased frequency	H 404		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

021102

1EW111

If continuation sheet 1 of 7

*Gemie alper* Home Care Director 8-14-08  
*Anthony J. Walker* Admin 8/13/08  
*MC acceptable* 8/20/08

New York State Department of Health

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H 404	766.3(b) Plan of care  766.3 Plan of care.  The governing authority or operator shall ensure that:  ..... (b) a plan of care is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential. This RULE: is not met as evidenced by: Based on a review of 2 patient records evidence is lacking in 2 records, 100%, that the Patient Nursing Assessments and Plans of Care included the complete functional limitation of each patient and the increased frequency of aide service needed at specific times for each patient through out the day.  Failure to include the complete functional limitations and the need for increased frequency	H 404	<i>So Pally Wilson 8/12/08 left message need signature &amp; then mail inquired</i>	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0945L001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/27/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREENPOINT SENIOR LIVING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 OLD LIVERPOOL ROAD LIVERPOOL, NY 13088</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
H 404	<p>Continued From Page 1</p> <p>of service on the patient's plan of care may lead to unmet patient needs and possible negative outcomes.</p> <p>Specifically:</p> <p>1. Patient # 1 is an [REDACTED] admitted to the Home Care Agency on 3/20/08 with a principle diagnosis of End Stage Renal Disease and a secondary diagnosis of Anemia. Nursing notes dated from the patient's start of care, 3/20/08, to 6/26/08 indicate that the patient vomits often at meals. A conversation with the Administrator revealed that the patient does better with an aide sitting at his table, telling the patient to slow down while eating and drinking. The Administrator and the Enriched Housing Coordinator [where the patient lived before coming to Home Care] stated that the patient has had this problem for a long time and that the patient's family and physician are aware of the situation. They also stated the patient has had a swallowing evaluation at another facility before moving to the facility. <u>No written evidence of the swallowing evaluation was found in the patient chart.</u></p> <p>The nursing assessment dated 3/20/08 and the patient's plan of care dated 3-20-08 to 9-20-08 failed to note the patient's history of vomiting at meal times due to eating too fast and the need for increased frequency of staff to sit with the patient at meal time.</p> <p>The Administrator stated that in the past while in home care, the patient had an aide sit with him at meals and the vomiting had stopped. The Administrator also stated that the patient no longer has an aide sitting with him at meals.</p> <p>No evidence of an aide sitting with the patient</p>	H 404	<p><b>H 404 Plan of Care</b></p> <p>Patient #1 Swallowing evaluation from 1/06 requested from physician for medical record. <i>OK 7/21/08</i> (Attachment #1)</p> <p>Care Plan meeting held with resident, son, Director &amp; Administrator on 7/15/08 regarding problems. Resident agreed to have HHA service at each meal, and to have a referral made to CHHA for swallow evaluation if MD permits. <i>OK 7/21/08</i> (Attachment #2)</p> <p>Orders sent to MD for additional aid service during meals. <i>OK 7/21/08</i> (Attachment #3) A + B</p> <p>Care Plan revised and updated to reflect change in service. <i>OK 7/21/08</i> (Attachment #4)</p>		

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H1016	<p>Continued From Page 4</p> <p>RN and the Administrator, evidence is lacking that the agency has employed a registered nurse to be responsible for the direction and supervision of all patient care and other health care activities of the agency.</p> <p>Failure of the agency to employ a registered nurse to be responsible for the direction and supervision of all patient care and other health care activities of the agency may lead to unmet patient needs and possible negative outcomes.</p> <p>Specifically:</p> <p>Upon the surveyor's arrival at the Home Care Agency a part-time RN told the surveyor that the RN Director responsible for the direction and supervision of the Home Care Patient Care Services and other health care activities, had resigned several weeks ago.</p> <p>At interviews with the Administrator and the part-time RN on 6/27/08, plus a copy of the Home Care employee schedule, dated 6/22-7/5/08, the agency has 2 part-time RN's assigned to Home Care. During an initial interview with 1 of the agency's part-time RNs, the RN stated that neither of the 2 RN's assigned to Home Care are willing at this time to accept the position of the RN Director.</p> <p>This surveyor asked the Administrator several times [ once in writing ] for the date the RN Director resigned. The information was not made available.</p> <p>No new evidence was found on 6/27/08 at interviews with the Administrator and 1 part-time RN.</p>	H1016	<p><b>H1016</b></p> <p><b>Governing Authority</b></p> <p>The Home Care Director, Gerri Petragnani, resigned her position effective 6/13/08.</p> <p>On 6/14/08 I met with Bonnie Alagna, RN, and she accepted the position temporary until a new Director could be recruited. (Attachment #10) 9</p> <p>On the day of survey, surveyor was provided with a current staff schedule that shows 1 full time RN employed and on call, and one part time RN that covers call for Acting Director while on vacation. Schedules attached going as far back as May 2008 showing Bonnie Alagna's full time status. She has been employed full time for over 3 years. (Attachment #10)</p> <p>We respectfully request this citation to be dismissed.</p>	<p>7/11/08</p> <p>discussed with Lynn Shannon &amp; Bill Wilson by phone</p> <p>Day of survey was not clear that Alagna was the new Director.</p> <p>6/28/08 Ri</p>	

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H1337	Continued From Page 5	H1337		
H1337	<p>766.11(f)(ii) Personnel</p> <p>Section 766.11 Personnel</p> <p>The governing authority or operator shall ensure for all health care personnel:</p> <p>(f)(ii) a criminal history record check to the extent required by section 400.23 of this Title</p> <p>This RULE: is not met as evidenced by: Based on a review of 8 personnel records [ hired within the last 12 months], evidence is lacking in 6 records that the agency had submitted the Home Health Aide's names and fingerprints for a criminal history record check as required by Title 10 NYCRR Part 402. 2 of the Home Health Aides [ #1 and #8 ] had checked on the consent for the criminal history back ground check that they had been convicted of a crime in New York State. Evidence is also lacking that the agency conducted the required weekly supervisions on the staff until DOH returned the results of the record check. Employees # <del>1</del>, <del>2</del>, <del>3</del>, <del>4</del>, <del>7</del>, <del>8</del>.</p> <p>Failure to submit personnel names and fingerprints for a criminal history record check and to do weekly supervision of the personnel until the results are returned may lead to unmet patient needs and possible negative patient care.</p> <p>Specifically:</p> <p>1. The personnel record for Home Health Aide # 8, hired 8/22/07, indicated that the Aide did have her finger prints submitted for a criminal background check on 9/28/07 but they were</p>	H1337	<p>H1337</p> <p>Personnel</p> <p>Home Health Aid #8 hired on 8/22/07 had finger prints submitted in May 08 and was cleared for hire. <i>ok 1/21/08</i></p> <p>(Attachment #12)</p> <p>Expedited forms completed and sent in on all staff without finger print submissions. Following staff returned with background completed (Gaines, Williams &amp; Tillis). <i>read Gaines 01/21/08</i></p> <p>Following staff fingerprinted and submitted to CHRC by mail on 7/3/08 (Rosetta, Matthews, Hines)</p> <p>Geller requires re-fingerprinting and completed on 7/15/08 for submission on 7/18/08.</p> <p>Weekly supervisions attached on Rosetta, Matthews, Hines &amp; Geller. <i>OK 7/30 weekly supervision</i></p>	

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H1337	<p>Continued From Page 6</p> <p>returned as unreadable. No evidence was found that the Home Health Aide had new fingerprints taken and re-submitted.</p> <p>2. Personnel records for Home Health Aides # 1, 2, 3, 4, 7, lacked evidence that fingerprinting of the aides had been done and submitted.</p> <p>3. The Home Health Aide personnel records indicated that the agency failed to conduct the required weekly supervision of Aides # 1, 2, 3, 4, 7, 8.</p> <p>At an interview with the Administrator, Assistant Administrator and a phone conversation with 1 part-time RN, on 6/27/08, no new evidence was found.</p>	H1337	<p>Administrative Assistant is responsible for submission of CHRC background checks.</p> <p>Director or Acting responsible for weekly supervision until completion of background investigation.</p> <p>Administrator to monitor quality assurance monthly.</p>	



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H 000	Initial Comments  This Statement of Deficiencies report is the result of a complaint [#08-06-30014] investigation. The survey consisted of the review of 2 patient records, review of the agency's policy on the destruction of controlled medication, review of 8 personnel records, interviews with 1 part-time Home Care Registered Nurse, 1 Home Care Licensed Practical Nurse, the Administrative Assistant, the Administrator, the Enriched Housing Coordinator, 2 patient home visits, 2 Home Care Aides, and 1 phone interview with a part-time Registered Nurse.	H 000		
H 404	766.3(b) Plan of care  766.3 Plan of care.  The governing authority or operator shall ensure that: ..... (b) a plan of care is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential. This RULE: is not met as evidenced by: Based on a review of 2 patient records evidence is lacking in 2 records, 100%, that the Patient Nursing Assessments and Plans of Care included the complete functional limitation of each patient and the increased frequency of aide service needed at specific times for each patient through out the day.  Failure to include the complete functional limitations and the need for increased frequency	H 404		

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H 404	<p>Continued From Page 1</p> <p>of service on the patient's plan of care may lead to unmet patient needs and possible negative outcomes.</p> <p>Specifically:</p> <p>1. Patient # 1 is an [REDACTED] admitted to the Home Care Agency on 3/20/08 with a principle diagnosis of End Stage Renal Disease and a secondary diagnosis of Anemia. Nursing notes dated from the patient's start of care, 3/20/08, to 6/26/08 indicate that the patient vomits often at meals. A conversation with the Administrator revealed that the patient does better with an aide sitting at his table, telling the patient to slow down while eating and drinking. The Administrator and the Enriched Housing Coordinator [where the patient lived before coming to Home Care] stated that the patient has had this problem for a long time and that the patient's family and physician are aware of the situation. They also stated the patient has had a swallowing evaluation at another facility before moving to the facility. No written evidence of the swallowing evaluation was found in the patient chart.</p> <p>The nursing assessment dated 3/20/08 and the patient's plan of care dated 3-20-08 to 9-20-08 failed to note the patient's history of vomiting at meal times due to eating too fast and the need for increased frequency of staff to sit with the patient at meal time.</p> <p>The Administrator stated that in the past while in home care, the patient had an aide sit with him at meals and the vomiting had stopped. The Administrator also stated that the patient no longer has an aide sitting with him at meals.</p> <p>No evidence of an aide sitting with the patient</p>	H 404			

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H 404	<p>Continued From Page 2</p> <p>during meals was found in the patient record.</p> <p>A nursing note dated 6/5/08 stated the patient had started on Mucinex 600 mg BID and that the patient had less vomiting at meals.</p> <p>Nursing notes on 6/25 and 26/08 state that the patient continues to vomit into his dishes at meals and that tablemates are very concerned.</p> <p>At an interview with the patient on 6/27/08 he told me that he does vomit if he eats too fast, that he sometimes forgets to eat slowly and acknowledges he needs reminders to slow down when eating and drinking.</p> <p>At an interview with the Administrator and the Enriched Housing Coordinator on 6/27/08 no new evidence was found.</p> <p>2. Patient # 2 is a [REDACTED] admitted to the agency's Home Care on 3/28/05 with a principle diagnosis of Dementia, and secondary diagnoses of Hypertension, Hyperlipidemia, and a history of Bladder Cancer. During interviews on 6/27/08 with the Administrator, the part-time RN and 2 Home Health Aides, it was stated that the patient has 24 hour care with 1 Home Health Aide plus another aide comes at scheduled times and when called as the patient is a 2 person assist during transfers and bathing.</p> <p>At the home visit the Home Health Aide stated that the an additional aide does come as scheduled on the Daily Assignment Aide Task A list, posted each day for all agency aides, and when called for additional assistance with transfers. A copy of the Daily Assignment Aide Task Sheet reveals a second aide is scheduled at 8 AM and 7:45 PM to assist with transfers, bathing, dressing.</p>	H 404			

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H 404	Continued From Page 3  The 24 hour aide does sign in on the in-home aide task sheet. No evidence was found in the patient record of sign in signatures or initials by additional aides.  Due to her diagnosis of dementia the patient was unable to answer the surveyor's questions to confirm that a second aide does assist as needed.  The nursing assessment dated 3/21/08 and the patient's plan of care dated 2/28 to 8/28-08 and the Home Health Aide Care Plan dated 5/14/08, failed to note the patient's need for additional aide service for bathing, dressing, and transferring.  At an interview with the Administrator on 6/27/08 no new evidence was found.	H 404			
H1016	766.9(h) Governing authority  Section 766.9 Governing authority.  The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: ..... (h) employ at least one licensed and currently registered professional nurse whose educational and experiential qualifications are deemed appropriate by the employing agency for the duties assigned, to be responsible for the direction and supervision of all patient care services and other health care activities of the agency. This RULE: is not met as evidenced by: Based on a review of the agency's Home Care staffing schedule and interviews with 1 part-time	H1016			

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H1016	<p>Continued From Page 4</p> <p>RN and the Administrator, evidence is lacking that the agency has employed a registered nurse to be responsible for the direction and supervision of all patient care and other health care activities of the agency.</p> <p>Failure of the agency to employ a registered nurse to be responsible for the direction and supervision of all patient care and other health care activities of the agency may lead to unmet patient needs and possible negative outcomes.</p> <p>Specifically:</p> <p>Upon the surveyor's arrival at the Home Care Agency a part-time RN told the surveyor that the RN Director responsible for the direction and supervision of the Home Care Patient Care Services and other health care activities, had resigned several weeks ago.</p> <p>At interviews with the Administrator and the part-time RN on 6/27/08, plus a copy of the Home Care employee schedule, dated 6/22-7/5/08, the agency has 2 part-time RN's assigned to Home Care. During an initial interview with 1 of the agency's part-time RNs, the RN stated that neither of the 2 RN's assigned to Home Care are willing at this time to accept the position of the RN Director.</p> <p>This surveyor asked the Administrator several times [ once in writing ] for the date the RN Director resigned. The information was not made available.</p> <p>No new evidence was found on 6/27/08 at interviews with the Administrator and 1 part-time RN.</p>	H1016		

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H1337	<p>766.11(f)(ii) Personnel</p> <p>Section 766.11 Personnel</p> <p>The governing authority or operator shall ensure for all health care personnel:</p> <p>(f)(ii) a criminal history record check to the extent required by section 400.23 of this Title</p> <p>This RULE: is not met as evidenced by: Based on a review of 8 personnel records [ hired within the last 12 months], evidence is lacking in 6 records that the agency had submitted the Home Health Aide's names and fingerprints for a criminal history record check as required by Title 10 NYCRR Part 402. 2 of the Home Health Aides [ #1 and #8 ] had checked on the consent for the criminal history back ground check that they had been convicted of a crime in New York State. Evidence is also lacking that the agency conducted the required weekly supervisions on the staff until DOH returned the results of the record check. Employees # 1, 2, 3, 4, 7, 8.</p> <p>Failure to submit personnel names and fingerprints for a criminal history record check and to do weekly supervision of the personnel until the results are returned may lead to unmet patient needs and possible negative patient care.</p> <p>Specifically:</p> <p>1. The personnel record for Home Health Aide # 8, hired 8/22/07, indicated that the Aide did have her finger prints submitted for a criminal background check on 9/28/07 but they were</p>	H1337		

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H1337	<p>Continued From Page 6</p> <p>returned as unreadable. No evidence was found that the Home Health Aide had new fingerprints taken and re-submitted.</p> <p>2. Personnel records for Home Health Aides # 1, 2, 3, 4, 7, lacked evidence that fingerprinting of the aides had been done and submitted.</p> <p>3. The Home Health Aide personnel records indicated that the agency failed to conduct the required weekly supervision of Aides # 1, 2, 3, 4, 7, 8.</p> <p>At an interview with the Administrator, Assistant Administrator and a phone conversation with 1 part-time RN, on 6/27/08, no new evidence was found.</p>	H1337		

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES**

 PRINTED: 03/31/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/12/2009
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NAME OF PROVIDER OR SUPPLIER

IDEAL SENIOR LIVING CTR LTHHCP

STREET ADDRESS, CITY, STATE, ZIP CODE

508 HIGH AVENUE

ENDICOTT, NY 13760

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G 000	<b>INITIAL COMMENTS</b>  The following statement of deficiencies represents the results of a full recertification survey, and an on site complaint investigation of complaint # NY00067186.  A standard level survey of the agency's Long Term Home Health Care Program (LTHHCP) was commenced on 03/05/09. On 03/06/09 deficiencies were identified with nursing services, and the survey was converted to a partial extended survey.  During the survey, a total of 13 clinical records were reviewed (1-13) with 3 observational home visits. Clinical records # 1, 3, 6, 8 - 13 were reviewed as part of the complaint investigation # NY00067186.  The required waived service of medical social work was reviewed in 6 patient records. Patients # 1, 3, 4, 5, 9, 12. There were no patients identified who were receiving the required waived services of respiratory therapy during the survey.  The following optional waived services were reviewed:  - Social Day Care and Social Transport for patients # 2, 9. On 03/06/09 an observational on-site visit was conducted by the surveyor for patient #2 at the day care facility facility.  - Ramp construction for patient # 3. On 03/06/09 an observational home visit was conducted.  - Meals on Wheels. Patients # 2, 6, 9, 10. On 03/06/09 an observational home (on site day	G 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Sham D. Ruppert, RN, BSN Director of Patient Services 04/27/09

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



PRINTED: 03/31/2009

FORM APPROVED

OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/12/2009
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NAME OF PROVIDER OR SUPPLIER  IDEAL SENIOR LIVING CTR LTHHCP	STREET ADDRESS, CITY, STATE, ZIP CODE 508 HIGH AVENUE ENDICOTT, NY 13760
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G 000 Continued From page 1  
(care) visit was conducted for patient #2.

- Personal Emergency Response System (PERS). Patients # 1-4, 6, 8, 9. On 03/06/09 observational home visits were conducted for patients # 1, 2, 3.

There were no patients receiving the following services during this survey: home improvement, home maintenance, facility based respite care, moving assistance.

The following contracts were reviewed for required and optional waived services on 03/12/09: medical social services, respiratory therapy, nutrition, home maintenance, home improvement, social day care and transport, respite care, meals on wheels, PERS, moving assistance. The agency does not provide congregate meal service.

Additionally reviewed during the survey were the agency's: policy and procedure manual; Professional Advisory Committee, and Governing Body, meeting minutes for the most recent twelve months; OBQI Adverse Event Outcome Report for the period of August 2008 to October 2008; Quality Assurance program; complaint investigation log; on-call log; contracts for professional services; emergency preparedness plan; and 13 personnel records, including the validation of 7 Home Health Aide certificates. Interviews were conducted with the Director of Patient Services, and the Intake and Therapy Supervisor.

All patient records were reviewed with the DPS during the course of the survey.

484.14 ORGANIZATION, SERVICES &

G 000

G 125

Clarification: Agency provides all Medical Social Services via directly employed staff and therefore does not have any contracts for Medical Social Services.

Clarification: Agency does offer congregate meal services but did not have any patients receiving this service during time of DOH survey. Contract was reviewed by DOH reviewer while on site during March survey that commenced 03/05/2009.

*accepted 4/30/09  
H Demartino*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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508 HIGH AVENUE

ENDICOTT, NY 13760

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G 125

Continued From page 2  
ADMINISTRATION

All services not furnished directly, including services provided through subunits are monitored and controlled by the parent agency.

This STANDARD is not met as evidenced by:  
Based on a review of 13 patient records, 3 observational home visits, and interviews with the Director of Patient Services (DPS), evidence is lacking in 8 records, and 1 home visit that the agency has effective policies and procedures in place to monitor the implementation and quality of waived services provided by contractual agreement, specifically, Meals on Wheels (MOW), Personal Emergency Response System (PERS), social day care, social transportation, and home modifications. Patients # 1, 2, 3, 4, 6, 8, 9, 10

Failure to ensure the quality of waived services has the potential for unmet patient needs, and possible agency wide negative patient outcomes.

Examples are as follows:

1. In 6 of 6 (100%) patient records reviewed (patients # 1, 2, 3, 4, 8, 6), where the plans of care included a Personal Emergency Response System (PERS), evidence is lacking the agency had a consistent formal process for monitoring the maintenance and proper functioning of the PERS units. Specifically, although checking the PERS units appeared on some plans of care, the agency failed to: ensure that a consistent policy is developed and implemented, or that the staff is educated and supervised, to ensure that it is clear: how the PERS units are to be checked; at

G 125

Develop QI Program for all waived services to include assessment of each vendor's QI program for the services the vendor provides to agency, periodic audits of vendor's QI program and records as appropriate to each service, on site visits on an annual basis to day care programs, comprehensive investigation of any complaints received about a waived service, a process to assess patient satisfaction with each waived service such as periodic phone surveys, and a method to assess quality of any construction project such as wheelchair ramps.

Staff Education: All staff will be inserviced on agency's QI program and expectations with respect to each type of waived service.

DPS and  
QI/Educ  
Coordinator -  
05/29/2009

DPS and  
QI/Educ  
Coordinator -  
05/29/2009

see B 3A  
accepted 4/30/09  
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G125

Personal Emergency Response Systems:

1. RN Case Managers to ensure that each patient's unit is checked at least once per month. If patient has aide service then this task will be delegated to the aide and noted on the Aide Care Plan. If patient does not have aide service, then per visits nurses will be prompted to remind patient to check PERS unit monthly and this will be so noted on the Problem List.
2. Any problems with PERS units will be reported to the RN Case Manager who will promptly call the PERS vendor and follow up as needed until the problem is resolved.
3. Any patient complaints regarding waived services will be documented and investigated per agency's Complaint Policy.
4. Patient satisfaction with all waived services will be assessed as follows:
  - RN will discuss patient satisfaction with waived services at joint visits with LDSS every 120 days.
  - Agency will complete 5 phone satisfaction surveys monthly assessing waived services.
5. Agency will monitor compliance with monthly checks of PERS units and assessment of patient satisfaction during comprehensive audit process.

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QI/Educ  
Coordinator -  
05/29/2009

Accepted 4/30/09  
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G126

Meals on Wheels and Congregate  
Meals:

1. RN Case Managers will confirm patient's diet order is physician ordered diet when service of Meals on Wheels or Congregate Meals is initiated and ensure that vendor is able to provide meals per physician's order.
2. During comprehensive reassessments, nursing will discuss meal service with patient and/or informal caregiver and assess that meals provided are per physician diet order.
3. Any patient complaints regarding waived services will be documented and investigated per agency's Complaint Policy.
4. Patient satisfaction with all waived services will be assessed as follows:
  - RN will discuss patient satisfaction with waived services at joint visits with LDSS every 120 days.
  - Agency will complete 5 phone satisfaction surveys monthly assessing waived services.
5. Agency will monitor compliance with nursing assessments of meal services and assessment of patient satisfaction during comprehensive audit process.

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6125

Social Day Care:

1. RN Case Managers will contact Day Care Program Coordinator within one week after patient's first visit to discuss role of home care agency in managing service and to assess patient's adjustment to the program. Ongoing contact with day care program will depend upon any issues or problems patient is having related to the service.
2. RN Case Manager or designee (such as MSW) will make a joint visit to the Day Care Program with patient if patient is having adjustment problems or there are other identified issues that warrant a site visit.
3. Any patient complaints regarding waived services will be documented and investigated per agency's Complaint Policy. Patient complaints are reviewed by the DPS and will result in a site visit by the DPS or designee if the nature of the complaint indicates need for this action.
4. Patient satisfaction with all waived services will be assessed as follows:
  - RN will discuss patient satisfaction with waived services at joint visits with LDSS every 120 days.
  - Agency will complete 5 phone satisfaction surveys monthly assessing waived services.
5. Agency will monitor compliance with RN Case Manager Care Coordination with Day Care and assessment of patient satisfaction during comprehensive audit process.

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Social Transportation:

- 9125
1. Intake Supervisor and/or RN Case Managers will assess patient's functional status and type of transportation assistance patient requires and based upon this assessment, determine need for Medivan transport versus Assisted or Unassisted Taxi transport and document this assessment in patient's record.
  2. During comprehensive reassessments, nursing will reassess patient's mobility status and verify that level of Social Transportation being provided is still appropriate and meets patient's need for assistance.
  3. Any patient complaints regarding waived services will be documented and investigated per agency's Complaint Policy.
  4. Patient satisfaction with all waived services will be assessed as follows:
    - RN will discuss patient satisfaction with waived services at joint visits with LDSS every 120 days.
    - Agency will complete 5 phone satisfaction surveys monthly assessing waived services.
  5. Agency will monitor compliance with RN Case Manager Care Coordination including nursing assessments of Social Transportation and assessment of patient satisfaction during comprehensive audit process.

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Home Maintenance Services:

1. All requests for Home Maintenance Services will be reviewed with DPS who will ensure that appropriate contracts and insurance binders are in place prior to engaging a specific vendor for this service.
2. Agency will obtain estimates as required by LDSS and ensure that LDSS has issued written authorization for the service prior to providing the service.
3. Upon completion of the service, agency will obtain patient's signature on a form that states that service has been completed to the satisfaction of the patient.
4. Any patient complaints regarding waived services will be documented and investigated per agency's Complaint Policy.
5. Patient satisfaction with all waived services will be assessed as follows:
  - RN will discuss patient satisfaction with waived services at joint visits with LDSS every 120 days.
  - Agency will complete 5 phone satisfaction surveys monthly assessing waived services.
6. Agency will monitor compliance with Home Maintenance authorization process and assessment of patient satisfaction during comprehensive audit process.

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G125

Home Improvement Services:

1. All requests for Home Improvement Services will be reviewed with DPS who will ensure that appropriate contracts and insurance binders are in place prior to engaging a specific vendor for this service.
2. Agency will obtain estimates as required by LDSS and ensure that LDSS has issued written authorization for the service prior to providing the service.
3. Agency will engage the services of a professional knowledgeable about construction standards and local building codes for each construction project that exceeds cost of \$500. In many cases this may be the building code inspector for the local municipality where the patient lives. Agency to meet with a local advocacy organization for people with disabilities (Southern Tier Independence Center) by 05/29/09 to discuss their potential role here.
4. Upon completion of the service, agency will obtain patient's signature on a form that states that service has been completed to the satisfaction of the patient.
5. Any patient complaints regarding waived services will be documented and investigated per agency's Complaint Policy.
6. Patient satisfaction with all waived services will be assessed as follows:
  - RN will discuss patient satisfaction with waived services at joint visits with LDSS every 120 days.
  - Agency will complete 5 phone satisfaction surveys monthly assessing waived services.
7. Agency will monitor compliance with Home Improvement authorization process and assessment of patient satisfaction during comprehensive audit process.

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		G125	<p>Example # 2</p> <p>2. Agency does verify frequency with which patients receive MOW services during monthly validation of vendor bills. Agency will implement formal QI Program for the waived service of MOW as outlined above under G 125.</p> <p>Patients# 2, 10 and 6 who receive the service of MOW will be assessed with respect to MOW compliance with prescribed diet order and patient satisfaction with the service as per the agency's QI program.</p>	DPS and QI/Educ Coordinator - 05/29/2009
			<p>Accepted 4/30/09 J. DeMartino</p>	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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125	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>- Patient # 2, the 01/27/09 plan of care included MOW 2 meals per day, 4 days per week.</li> <li>- Patient # 10, the 01/17/09 plan of care included MOW 1 meal per day, 7 days per week</li> <li>- Patient # 9, the 05/21/08 plan of care included MOW 2 meals per day, 5 days per week</li> <li>- Patient # 6, the 02/09/09 plan of care included MOW 2 meals per day, 7 days per week.</li> </ul> <p>Evidence is lacking the agency monitored: if the above services were provided to the patient at the frequency specified in the plan of care, if the patient's dietary restrictions were being adhered to by MOW, if the patient was satisfied with the quality of food.</p> <p>3. In 2 of 2 patient records reviewed (patients # 2, 9), where the patient was receiving social day care services with social transport contracted by the agency, evidence is lacking the agency monitored the quality of services provided by the vendors providing the day care and transportation services as follows:</p> <ul style="list-style-type: none"> <li>- For patient # 9, the 02/10/09 physician order included social day care services 1 day per week. Evidence is lacking the agency monitored the frequency and quality of services provided by the day care center and transport vendor.</li> <li>- For patient # 2, the 01/27/09 plan of care included social day care services 3 times per week. Evidence is lacking the agency monitored the frequency and quality of services provided by the day care center and transport vendor.</li> </ul> <p>HV</p> <p>4. Patient #3 was admitted to the agency on</p>	G 125	<p>3. Comprehensive QI program for the services of Social Day Care and Social Transportation will be developed as outlined above under G 125.</p> <p>For patients# 9 and 2, agency will assess frequency and quality of Day Care and Transport services as per agency's QI program.</p> <p><i>accepted 4/30/09</i> <i>J. De Martin</i></p>	<p>DPS and QI/Educ Coordinator - 05/29/2009</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 125 Continued From page 5  
02/26/08. Evidence is lacking the agency monitored and ensured that a temporary ramp, which was provided by a vendor contracted by the agency, was constructed to local standards. See 700.11.

On 03/09/09 and 03/12/09 the above information for all patients was reviewed with the DPS. The DPS stated that the agency does not have policy or procedure in place to monitor all waived services being provided to the patients.

G 140 484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE

Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).

This person, or similarly qualified alternate, participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.

This STANDARD is not met as evidenced by: Based on a review of 13 clinical records, and interviews with the Director of Patient Services (DPS), evidence is lacking in 11 records (patient # 1-3, 6-13) that the following supervisory responsibilities are being performed:

- Ensuring that coordination/case management is being performed consistently, and that all pertinent patient information is communicated to all individuals providing care, and documented in the clinical record. See G 143, G 144

G 125

4. Agency will meet with vendor of portable ramp to assess their process to assure local standards are being followed. For further details, please refer to agency's plan for QI program for the service of Home Improvement outlined above under G 125.

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05/29/2009

G 140

Problem List Development: - see G 143, G 171, G 172  
Staff Education and Inservices: - see G 143, G 158, G 159, G 164, G 172, G 225  
Comprehensive Audits and Plan of Care Audits: - see G 143, G 158, G 159, G 164, G 171, G 172  
Focus Audits: - see G 158, G 164  
Case Conferences: - see G 144  
Medication Reconciliation: - see G 159  
Nursing Supervision: - see G 164, G 171, G 172  
Aide Care Plan Policy Revision: see G 225

Accepted 4/30/09  
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G 140 Continued From page 6

- Ensuring that each patient's plan of care is complete and accurate for all diagnoses, medications and treatments, and is being implemented by all disciplines. See G 158, G159

- Ensuring that the agency's professional staff promptly alerts the physician to any changes in the patient's condition that may suggest a need to alter the plan of care. See G 164

- Ensuring that nursing assessments and reassessments are complete, and accurately reflect the patient's status and continuing needs. See G171, G172

- Ensuring that all personnel assigned to patient care are qualified to implement the plan of care, and are clear in their job duties, and that the plans of care can be safely implemented. See G 225

Examples are as follows:

1. Patient # 12 was an [redacted] admitted to the agency on 12/18/07 with a primary diagnosis of rheumatoid arthritis. Evidence is lacking the SN adequately supervised the Home Health Aide (HHA) as follows:

- On the 12/18/07 the Skilled Nurse (SN) performed an initial nursing assessment. The SN documented that the patient and his son reported that the patient is a 1 person assist with walker, to transfer, and that the patient had a hooyer lift. Evidence is lacking the SN actually assessed the patient's gait, ability to transfer, bed mobility, or use of his wheelchair and hooyer lift, or consulted with the nursing supervisor, prior to assigning a

G 140

1. Patient #12 was discharged from agency on 04/09/2008. RN who completed the initial assessment for this client was counseled/coached regarding the need to comprehensively assess a client's functional status before an accurate aide care plan can be developed.

Completed  
12/28/2007 by  
DPS

Accepted 4/30/09  
H. Demanetue

PRINTED: 03/31/2009  
FORM APPROVED  
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/12/2009
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

DEAL SENIOR LIVING CTR LTHHCP

508 HIGH AVENUE  
ENDICOTT, NY 13760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 140	<p>Continued From page 7 HHA to care for the patient.</p> <p>- On 12/19/07 the aide documented a phone call to the SN to report that she (the aide) could not transfer the patient off of the commode. The aide was instructed to call the local emergency services for help. Although the patient continued to receive daily aide service, evidence is lacking the SN reassessed the patient until 8 days later on 12/26/07.</p> <p>- On 12/26/07 the SN visited the patient, however, failed to: reassess the patient's ability to transfer, determine why the patient had been unable to transfer the patient on 12/19/08, or develop a transfer plan which could be safely implemented by the aide until 01/04/07.</p> <p>- On 12/19/07 the Physical Therapist (PT) visited the patient, and documented she (the PT) assisted the aide to transfer the patient from the wheelchair to a lift chair. The PT also contacted the patient's physician to request an order for a Hoyer lift, hospital bed, commode and wheelchair cushion. Evidence is lacking the patient had a hoyer lift as the SN initial assessment indicated. Although the agency continued to provide daily aide services, there is no evidence that the PT and SN discussed a safe transfer plan for the patient until 01/04/07.</p> <p>- On 12/20/07, a scheduling note documented that the aide was instructed not to transfer the patient as she was not oriented to the Hoyer lift. Evidence is lacking the SN made a supervisory visit that day to orient the aide in the use of the hoyer lift, and it is unclear how the patient was transferred that day.</p>	G 140		

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G 140	Continued From page 8 This record was reviewed with the Director of Patient Services and the Therapy Intake Supervisor on 3/9/09. No new evidence was provided.	G 140
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G 140

2. HHAs currently providing care for Patient #9 have been counseled and instructed on the need to follow the HHA Care Plan with respect to medication reminders and the importance of documenting this task on their Aide Activity Sheet for each visit and reporting to the RN Case Manager patient non-compliance.

Aide Supervisor  
04/10/2009

3. HHA Care Plan for Patient #11 has now been updated and is current.

**Clinical Team**  
**Leader 04/10/09**

The patient record was reviewed with the DPS on 03/11/09. No additional information was provided.

Lack of adequate supervision has the potential for unmet patient needs and possible negative patient outcomes.

G 143 484.14(g) COORDINATION OF PATIENT SERVICES

G 143

G140. cont. on 9A

Accepted 4/30/05  
H. Demantini

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Other patients listed with G140:Patient #1 - See G 143, 144, 158, 164,  
172Patient #2 - See G 144, 158, 159, 164,  
171, 172Patient #3 - See G 143, 144, 158, 159,  
164, 172, 225Patient #6 - See G 144, 158, 171, 172,  
225Patient #7 - See G 143, 144, 159, 164,  
171Patient #8 - See G 143, 144, 158, 159,  
225Patient #10 - See G 143, 144, 158, 159,  
164

Patient #13

Patient  
discharged from  
agency 02/11/09Accepted 4/30/09  
A. Demantino



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G 143

Continued From page 9

All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.

This STANDARD is not met as evidenced by: Based on a review of 13 clinical records, and interviews with the Director of Patient Services (DPS), evidence is lacking in 8 records that the Skilled Nurses (SN) are consistently functioning in the role of case manager / case coordination, or that they have a clear understanding of their role in providing case management and coordination. Patients # 1, 3, 5, 7, 8, 9, 10, 11

Lack of adequate case management and case coordination has the potential for unmet patient needs and possible negative patient outcomes.

Examples are as follows:

1. Patient # 8 was admitted to the agency on 7/16/99 with a secondary diagnosis of type 2 diabetes. The 02/02/09 plan of care specified the patient was to check her blood sugar 1 time per day, and that the SN was to instruct the patient in: glucometer maintenance, signs and symptoms of hypoglycemia and hyperglycemia, and to report to the physician glucose levels under 60 or over 300. The plan of care also included daily Home Health Aide (HHA) service, and that the aide is to assist the patient with blood sugar testing every morning. Evidence is lacking the SN coordinated a plan for diabetes management as follows:

- Although the SN visited the patient on 11/11/08 and 11/19/08, evidence is lacking the SN assessed the patient's blood glucose, and failed

G 143

**Problem List Development:** A multidisciplinary problem list has been developed and is now maintained in the agency's point of care system (computer system) for each client. This is a tool that lists all treatments as ordered by the physician on both the POC and on supplemental orders and identifies who is responsible to provide the care. The development of the Problem List begins with the Intake Supervisor and then the RN Case Manager is responsible for the initiation and maintenance of the formal problem list on an ongoing basis. All professional staff have access to this list and have the ability to add to and modify the list. The Multi-disciplinary Problem List is a communication tool to cue all professional staff on each client's specific orders and will also be used by the nursing staff to enable them to build the POC at the time of the next reassessment.

**Staff Inservice and Education:** Problem List, Case Coordination, following the Plan of Care, Communication with the Physician and Effective Home Care Documentation.

Series of Comprehensive Case Management Inservices for Nursing Staff - initial comprehensive Case Management Inservice will occur during the month of May 2009

Clinical Team  
Leaders and  
QI/Educ  
Coordinator:  
Problem lists  
completed.  
04/20/2009

DPS and  
QI/Educ  
Coordinator  
04/24/09

QI/Educ  
Coordinator and  
DPS - 05/29/09  
and ongoing

*Accepted 4/30/09*  
*J. Remautin*

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STREET ADDRESS, CITY, STATE, ZIP CODE

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ENDICOTT, NY 13760

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		2143	<p><u>Comprehensive Audits and Plan of Care</u> Audits: Current audit tools to be assessed and revised and agency staff to be inserviced with respect to completing an effective comprehensive and plan of care audit. See G 250 Conduct audits: comprehensive audits - minimum of 10 per month and for plan of care audits - 100% of start of care and resumption of care plan audits and a minimum of 50% of recertification plan audits. <u>** POC audits will include an audit of the initial nursing assessment for SOC and ROC audits and an audit of nursing reassessments for recent POC audits. See G250</u></p>	<p>QI/Educ Coordinator - 05/15/2009</p> <p>QI/Educ Coordinator - Audits to begin by 05/18/09</p>

*Accepted 4/30/09  
J. Demartino*

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143

Continued From page 10

to document why she had not assessed the patient's blood glucose.

- On 11/24/08 the SN visited the patient, and documented the patient had not had a battery for her glucometer for several weeks, was planning on purchasing the batteries the following week, had felt the symptoms of low blood sugar a few times and just ate something to compensate for the low blood sugar. Evidence is lacking the SN identified that the lack of a glucometer required immediate intervention, ever assisted the patient in obtaining batteries for the glucometer, reported to the physician that the patient's blood glucose was not being assessed per the plan of care.

- On a 11/26/08 it is documented in a contact message that the aide reported to the agency that the patient appeared to have low blood glucose, and was falling asleep in her wheelchair. The patient ate part of a sandwich and stated to the aide she felt better and told the aide to leave, which the aide did. Evidence is lacking the SN coordinated a plan to: reassess the patient's blood sugar until 6 weeks later on 01/14/09, ensure the patient's glucometer was functioning, or that the patient ever secured batteries for the glucometer. Instead the SN documented only that she attempted to call the patient 2 times, however, the line was busy.

This record was reviewed with the Director of Clinical Services and the Therapy Intake Supervisor on 3/9/09. No new evidence was provided.

2. Patient # 12 was admitted to the agency 12/18/08 from a skilled nursing facility. The plan of care included daily HHA services. On 12/26/08

G 143

Example 1 from pg 10

1. Review of clinical documentation for recent SN visits indicates that SN assessment of endocrine system is being completed at each visit as per the plan of care for patient #8. Patient's glucometer is functional and has working batteries.

Clinical Team  
Leader 04/10/09Accepted 4/30/09  
H. K. Martinez

2. Patient # 12

Discharged from  
the agency on  
04/09/2008.

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143	<p>Continued From page 11</p> <p>the SN visited the patient and documented: the patient was incontinent, the son should start a 2 hour bladder training program, the son preferred to use a condom catheter.</p> <p>On 12/27/08 the SN phoned the patient and discussed with the son that the patient's functional status was deteriorating since his discharge from the skilled nursing facility. Evidence is lacking the SN coordinated a plan of care to meet the patient's decreasing functional status, and failed to coordinate a plan for the patient's incontinence. Specifically, the SN failed to: discuss her recommendation for bladder training vs a condom catheter with the physician, follow up with the primary caregiver to instruct the caregiver in the finalized plan, coordinate the incontinence plan with the HHA. Instead, on 01/03/09, the SN documented that SN services were not needed as frequently as the plan of care specified, and obtained a physician order to decrease SN visit frequency from 1 time per week to 2 - 3 times per month times per month.</p> <p>The patient record was reviewed with the DPS on 03/12/09. No additional information was provided.</p> <p>3. Patient # 2 was admitted to the agency on 01/27/09. The 01/26/09 discharge summary from the skilled nursing facility indicated the patient had a peritoneal dialysis site which should be cleansed weekly. The 01/27/09 initial nursing assessment documented the patient had a peritoneal dialysis catheter, which had a 4 x 4 (gauze) dressing which would "reportedly be discontinued at dialysis." Evidence is lacking the SN coordinated a plan with the dialysis center or physician for the care of the catheter, including who would be responsible for it's care.</p>	G 143	<p>3. Peritoneal dialysis catheter for patient #2 was removed 03/16/2009 and therefore, agency no longer has need to assess or provide care to this site. Patient has 2 hemodialysis sites: one is right upper chest wall and agency has clarified that the dialysis center is to change the dressing at this site weekly and assess the site at every visit which is three times per week. Patient also has an AV dialysis shunt in left forearm that has two small healed incisions and this site also assessed by dialysis center 3 x week. Physician orders obtained for this plan.</p>	Clinical Team Leader 04/10/09

Accepted 4/30/09  
L. D. Martin

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Other patients listed with G 143:

*G 143*  
Patient #1- Per DOH verbal feedback during survey, POC calls for nurses to monitor blood glucose levels and weight. Patient non-compliant with monitoring blood glucose levels and agency unable to weigh patient due to his size and mobility status. POC has been discussed with physician and changes include that patient will have lab work drawn at physician's office to monitor blood glucose levels and nurses to now assess client's size visually and by measuring bilateral lower extremities and will notify physician for any changes of greater than 2 cm.

Patient #3 - Per DOH surveyor verbal feedback during survey, POC calls for assessment of O2 sats prn cough or SOB. Patient's acute sinus infection has been resolved and there have been no further respiratory signs or sx indicating a need to assess O2 sats. Surveyor also noted that skin assessments were not being done every visit - review of recent skilled nursing notes dated 04/10 and 04/17/09 indicate that skin assessment was completed and this task has been added to Patient's Problem List to cue nurses to assess and document skin every visit.

Patient #5

Patient #7 - Per DOH surveyor verbal feedback during survey, 4 skilled nursing notes indicated increased redness and swelling of the knee and there is no evidence this was reported to the physician. This was surgical incision and nursing notes now indicate that the surgical is healed and this is a resolved issue.

Clinical Team  
Leader 04/10/09

Clinical Team  
Leader 04/17/09

Patient #5  
discharged from  
agency on  
02/10/09.

Clinical Team  
Leader 04/10/09

*accepted 4/30/09  
H. DeMartino*

12A

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G143

Patient #9 - Per DOH surveyor verbal feedback during survey, nursing was documenting that patient was non-complaint with medications and diet and there were no evidence of nursing follow up. On 3/16/09, POC was updated to include increased emphasis on patient education regarding medication and diet compliance and patient's non-compliance in these areas have been reported to the physician. On 04/15/09, Patient's Problem List was developed and cues nurses to assess medication compliance, nutritional status and weight patient at every visit.

Clinical Team  
Leader 04/17/09

Patient #10 - Per DOH surveyor verbal feedback during survey, patient reports pain level of 6-7 out of 10 and was taking Tylenol. There was no nursing documentation indicating whether Tylenol was effective. Recent skilled nursing assessments indicate that patient's pain level has been 3-5 out of 10 and that patient is taking Tylenol 650 mg po prn pain and reports that Tylenol is effective. On 04/17/09, pain assessment was included on patient's newly developed Problem List to cue nurses to complete pain assessments.

Clinical Team  
Leader 04/17/09

Patient #11 - Per DOH surveyor verbal feedback during survey, patient's PCA service was on hold during the week of 02/16/09 and these missed visits were not reported to the physician. Agency has now developed a procedure and form for reported missed aide visits to the physician. See G 158

DPS - 04/17/09

Accepted 4/30/09  
L. A. Martin

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S 143	Continued From page 12  Additionally the SN documented that the patient had an occlusive dressing on a hemo dialysis site on her right upper chest. Evidence is lacking the SN coordinated a plan for the care of the site, with the dialysis center and physician, including who would be responsible for the care. There is also no evidence the SN consulted with the Nursing Supervisor.  The patient record was reviewed with the DPS and Therapy and Intake Supervisor, no additional information was provided.	G 143		
S 144	484.14(g) COORDINATION OF PATIENT SERVICES  The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.  This STANDARD is not met as evidenced by: Based on a review of 13 clinical records, review of agency policies, and an interview with the DPS, evidence is lacking in 13 records, that case conferences are being conducted on a regular basis, and that there is a mechanism for effectively communicating changes in the patient's condition. Patients # 1-13 See G 140, G 143  Specifically, the agency's Coordination of Care/Case Management policy indicates that case conferences will take place at least every 60 days, or more often if necessary.  During an interview conducted with the DPS on	G 144	<p><b>Case Conferences:</b> Agency will reinstate formal case conferences for every client at least every 60 days. Clients receiving high tech services will be formally case conferenced every month. Case conference guidelines have been reviewed and updated to include use of the Multi-Disciplinary Problem List to assure all client issues are reviewed at each conference. Establish schedule of case conferences for the remainder of the calendar year to 2009. Implement formal case conferences.</p> <p><b>Staff Education and Inservice:</b> Formal and informal case conferences and effective Home Care Documentation for case conferencing. Staff have been inserviced on importance of documenting all informal case conferences that occur frequently as staff coordinate a client's care and work together. <b>Case Conference QI:</b> Frequency of case conferences will be assessed as part of comprehensive audits. See G 250</p>	<p>DPS 04/13/09</p> <p>DPS 05/08/09 DPS 05/22/09</p> <p>QI/Educ Coordinator and DPS 04/24/09 QI/Educ Coordinator 05/29/09</p>

Accepted 4/30/09  
A Demantini

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STATEMENT OF DEFICIENCIES 3. PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/12/2009
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G 144	Continued From page 13 03/12/09, the DPS stated that due to staffing issues they have not been conducting patient care conferences every 60 days per agency policy for the past several months, and that she is planning on reinstating the implementation of this policy.  Lack of adequate coordination of care and case management has the potential for unmet patient needs and possible negative patient outcomes.	G 144	<u>Patients listed with G 144:</u> Patients # 1, 2, 3, 4, 6, 7, 8, 9, 10, 11 have been scheduled for formal case conference in May of 2009.  Patient # 5  Patient # 12  Patient # 13	DPS 05/29/2009  Discharged from agency on 02/10/09 Discharged from agency on 04/09/08 Discharged from agency on 02/11/09
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.  This STANDARD is not met as evidenced by: Based on a review of 13 clinical records, and interviews with the Director of Patient Services (DPS), evidence is lacking in 9 records that the plan of care is consistently being followed. Patients # 1, 2, 3, 6, 8, 9, 10, 11, 13  Failure to follow the patient plan of care has the potential for unmet patient needs and possible negative patient outcomes.  Examples are as follows:  1. Patient # 9 was admitted to the agency on 03/21/08. The 11/16/08 and 01/15/09 plans of care included weekly Skilled Nursing (SN) visits to pre pour the patient's medications. Evidence is lacking the plan of care was followed as follows:  - The SN failed to visit the patient for a 9 day period from 01/02/09 to 01/11/09.	G 158	<u>Reporting Missed Visits to Physician:</u> Agency has developed and inserviced staff on specific guidelines when each discipline is not able to provide service as per the POC: 1. Each professional discipline (SN, PT, OT, ST, MSW, RD) is responsible to inform the physician if visits are not provided as per the POC for their specific discipline. 2. For all levels of aide service, agency has developed a form "Notification of Change in Service" that is completed when aide service is not provided as per the POC. RN Case Manager signs off on this form to assure RN Case Manager is aware and then Aide Scheduler faxes this completed form to the physician notifying the physician that service was missed along with the reason for the missed visit.	DPS 04/17/2009

Accepted 4/30/09  
H. H. Martine



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NAME OF PROVIDER OR SUPPLIER  IDEAL SENIOR LIVING CTR LTHHCP	STREET ADDRESS, CITY, STATE, ZIP CODE 508 HIGH AVENUE ENDICOTT, NY, 13760
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G158

Staff Inservice and Education:

Following the Plan of Care,  
Communication with the Physician,  
Aide Orientation and Supervision, Aide  
Care Plans, Aide Activity Sheets, and  
Effective Home Care Documentation.  
Above inservices completed for non-aide  
staff.

Home care Aides will be inserviced on  
Aide Care Plans and Aide  
documentation in May 2009.

Comprehensive Audits and Plan of Care  
Audits: see G 143

Focus Audits: Monthly focus audits:  
1. Following plan of care for frequency  
of service - 10 per month.  
2. Aide documentation and congruency  
of Aide care Plans and the Plan of Care  
for Aide service - 10 per month.  
These two focus audits will be  
completed ongoing until a target  
compliance threshold of 95% has been  
reached and then need to continue each  
audit will be re-evaluated.

Development of audit tools and  
procedures for each focus audit above  
and train staff in auditing procedure.

Implement both focus audits as above.  
See 250 for more details on QI Program.

QI/Educ  
Coordinator and  
DPS 04/24/09

Aide Supervisor  
05/29/09

QI/Educ  
Coordinator -  
05/15/2009

QI/Educ  
Coordinator -  
05/18/09

Accepted 4/30/09  
J. Remontine

14A

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 158

Continued From page 14

- On 01/11/09 the SN visited the patient and documented the patient had not taken his medications for two days, and that the patient was experiencing dizziness at times. The SN failed to report to the physician that she was 2 days late in filling the patient's med sorter which resulted in the patient not taking his medications for 2 days, and the patient was experiencing dizziness.

- The 11/16/08 and 01/15/09 plan of care included reporting weight fluctuations of 2-5 pounds to the physician. On 12/26/08 the SN documented the patient's weight as 165 lbs. Evidence is lacking the SN reported the following weights to the physician per the plan of care:  
01/02/09 184 lbs, representing a 19 lb weight gain from the prior visit  
01/17/09 192 lbs, representing an 8 lb weight gain from the prior visit  
02/12/09 180 lbs, representing a 12 lb weight loss from the prior visit  
02/20/09 194 lbs, representing a 14 lb weight gain from the prior visit

- The 11/16/08 plan of care included Personal Care Aide (PCA) visits 3 times per week, however, only 2 PCA visits were made for the weeks of 11/23/08, 12/21/08, and 12/28/08.

- The 11/16/08 plan of care included daily weights by the Home Health Aide (HHA), however between the dates of 11/17/08 and 03/05/09, evidence is lacking the aide ever weighed the patient.

- The 11/16/08 CMS 485 plan of care included daily medication reminders by the HHA. Between

G 158

G 158 Example 1. cont. from pg 14

1. Patient #9 -SN assessment and visit to pre-fill medisorter is now occurring consistently every 7 days as per POC order for SN visit every week. Patient is now being weighed at every SN visit and Case Manager is monitoring weights and will report patient weight changes to the physician as per agency parameters. No further complaints of dizziness are noted and SN assessment indicates improved medication compliance. Current HHA Care Plan does not indicate that HHA weigh patient daily. Home Care aides have been counseled about the need to follow the aide care plan and document per the plan specifically with respect to medication reminders, bathing, skin care, and the need to check the PERS unit.

Aide Supervisor  
and Clinical  
Team Leader  
completed  
04/10/09

Accepted 4/30/09  
A. De Martine

PRINTED: 03/31/2009

FORM APPROVED

OMB NO. 0938-0391

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G 158

Continued From page 15  
the dates of 11/17/08 and 03/05/09 evidence is lacking the HHA reminded the patient to take his medications 25 of the 41 visits made.

- The 11/16/08 plan of care included daily bathing and skin care by the HHA. Between the dates of 11/17/08 and 03/05/09 evidence is lacking the HHA bathed or provided skin care to the patient 26 of the 41 visits made.

- Evidence is lacking the HHA checked the PERS system weekly per the 11/16/08 plan of care.

The patient record was reviewed with the DPS on 03/10/09. No additional information was provided.

2. In 6 of 13 patient records reviewed, evidence is lacking the plan of care was followed for frequency of HHA and/or PCA and/ or SN services. Patients # 3, 6, 8, 9, 10, 11

Specifically:

- Patient # 11 was admitted to the agency on 01/12/09 with a secondary diagnosis of type 2 diabetes. The 01/12/09 plan of care included weekly SN assessments to perform blood glucose testing, however, evidence is lacking an RN visited/assessed the patient for 4 weeks, from 01/14/09 to 02/11/09.

Additionally, the 01/12/09 plan of care included PCA services 3 times per week, however there were no PCA visits during the week of 02/16/09. Although there is a note in the patient record indicating the services were on hold, evidence is lacking this was reported to the physician.

- Patient # 8 was admitted to the agency on

G 158

2. Patient # 11 is now receiving SN visits at the frequency ordered in the POC - every week. SN performing chemstrip at every visit and blood glucose readings have been within agency parameters. Procedure has been developed for notifying physician when aide visits are not provided as ordered - see above.

Patient #8 is now consistently receiving SN assessment every 2 weeks. Agency completed audit of aide visits while DOH on site and was able to provide evidence of all missing aide visit documentation except for the visits cancelled by the patient - surveyor verbally acknowledged to DPS that all documentation was accounted for. Procedure has been developed for notifying physician when aide visits are not provided as ordered - see above. Patient #3 is now consistently receiving SN assessments and visits per the POC ordered frequency.

Clinical Team  
Leaders  
completed  
04/10/09

Accepted 4/30/09  
H Remantini

PRINTED: 03/31/2009

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G 158 Continued From page 16

07/16/99 with a primary diagnosis of quadriplegia. The 10/05/08 and 12/01/08 plans of care included SN assessments 2 times per month, however, evidence is lacking a SN visit was made for 4 weeks, from 11/26/08 to 12/31/08.

Additionally, the 02/02/09 plan of care included PCA services 3 times per day, however the patient failed to receive 12 PCA visits for the month of February. Specifically, although the patient cancelled on 2 occasions, and was not home on another 2 occasions, the agency failed to provide PCA services per the plan of care for 8 additional visits. Evidence is lacking the physician was ever notified that the plan of care was not followed.

- Patient # 3 was admitted to the agency on 07/11/08 with a secondary diagnosis of paralysis of the lower extremities. The 11/11/08 and 01/01/09, and 02/07/09 plans of care included weekly SN visits for assessment. Evidence is lacking an RN visited the patient for assessment between the following dates: 12/05/08-12/14/08, 01/04/09 - 01/13/09, 02/13/09 - 02/27/09.

The patient records for patients # 3 and 8 were reviewed on 03/09/09 with the DPS and the Intake and Therapy Supervisor. The patient record for patient # 11 was reviewed with the DPS on 03/10/09. No additional information was provided.

3. Patient #6 was admitted to the agency on 06/16/08. The plan of care included PCA visits 5 times per week, and the PCA care plan included nail and foot care at every visit, snack preparation at every visit, medication reminder at every visit. Between the dates of 02/03/09 and 03/03/09 the

G 158

3. Aide supervisor has counseled and instructed all PCAs caring for patient #6 to provide care and document according to PCA care plan and specifically to include nail and foot care, snack preparation, medication reminders, and to check the PERS unit at the specified frequency.

Aide Supervisor  
completed  
04/10/09

Accepted 4/30/09  
H. DeMatine

PRINTED: 03/31/2009

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			CONF G 158	

Other patients listed with G 158:

Patient # 1 - Per DOH surveyor verbal feedback during survey, agency had orders for SN visit every week to change UNNA boots and visit on 02/06/09 was 6 days from the previous visit and 02/18/09 visit was 8 days since previous visit. Agency is now consistently completing SN visit for this patient every 7 days to manage his UNNA boots.

Clinical Team  
Leader 04/10/09

Patient #2 - Per DOH surveyor verbal feedback during survey, patient had orders for PCA services 4 X week but service was only provided 2 X week. Agency notes that shortly after admission, patient requested to not have aide service on the weekends and only requested service 2 X week. Agency has obtained a supplemental physician order for PCA services 2 X week.

Clinical Team  
Leader 04/22/09

Patient #10 - Per DOH surveyor verbal feedback during survey, agency orders for nursing were 2 X month and this is not acceptable. Physician orders have been obtained for SN frequency of every 2 weeks.

Clinical Team  
Leader 04/10/09

Patient #13

Discharged from  
agency on  
02/11/09

Facility ID: 3548

If continuation sheet Page 31 of 37

Accepted 4/30/09  
H. Romanine

p 17A

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G 158	Continued From page 17 PCA failed to: perform nail and foot care for 15 of 16 visits, prepare a snack for 12 of 21 visits, remind the patient to take medications 14 of 16 visits.  Additionally, the PCA failed to test the PERS weekly per the plan of care.  The patient record was reviewed with the DPS on 03/10/09. No additional information was provided.	G 158		
G 159	484.18(a) PLAN OF CARE  The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.  This STANDARD is not met as evidenced by: Based on a review of 13 clinical records, and interviews with the Director of Patient Services (DPS), evidence is lacking in 11 records that the plan developed is of sufficient scope to meet the patient's needs. Patients # 2 - 5, 7 - 13  Failure of agency staff to develop a plan of care to meet all of the patient's needs has the potential for unmet patient needs and possible negative patient outcomes.  Examples are as follows:  HV	G 159	<u>Medication Reconciliation:</u> Agency will revise Medication Management policy to require SN to complete a comprehensive medication reconciliation at every SOC and ROC; at the next SN visit following the SOC or ROC, and ongoing on a weekly basis unless orders for SN frequency is less than weekly, than medication reconciliation will be completed at every SN visit. <u>PICC Line Policy:</u> Agency will review/revise policy for comprehensive care of a PICC line to include assessment and care of the PICC line. <u>Tracheostomy Care Policy:</u> Agency will review/revise policy for comprehensive assessment and care of a tracheostomy. <u>Developing the Plan of Care Policy:</u> Agency will review/revise policy on developing the client plan of care. <u>Staff Education:</u> 1. Medication reconciliation and management, and Effective home care documentation. 2. Policies on Developing Client Plan of Care, PICC line, and Tracheostomy.  <u>Comprehensive Audits and Plan of Care Audits:</u> see G 143	DPS - 05/15/09  DPS - 05/15/09  DPS - 05/15/09  DPS - 05/15/09  QI/Educ Coordinator and DPS 04/24/09 QI/Educ Coordinator and DPS 05/29/09

Accepted 4/30/09  
H. R. Martinez

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G 159	Continued From page 18 1. Patient #3 was admitted to the agency on 07/11/08. On 03/06/09 the surveyor made an observational home visit with the SN. Although the SNs had been visiting the patient weekly from 07/11/08 to 03/06/09, evidence is lacking the SNs identified the following discrepancies in the 02/07/09 plan of care:  - The plan of care included canasa every hour of sleep, however, the patient stated he had not taken this medication since 2008 at the direction of his physician.  - The plan of care included caltrate twice daily, however, the patient stated he had not taken this medication for 3 months.	G 159	1. Patient #3 - RN Case Manager completed a comprehensive medication reconciliation, verified all current medications patient is currently taking with patient's spouse who manages patient's medications, and verified any discrepancies with physician. Physician supplemental orders have been completed. Specific medications reconciled are as follows:	Clinical Team Leader 04/24/09
	- The plan of care included cymbalta 60 mg twice daily, however, the patient stated he had been taking 30 mg, 3 times per day for 4 months at the direction of his physician.  - The plan of care included desyrel, however the patient stated he is no longer taking this medication at the direction of his physician.  - The plan of care included fosamax once per week, however, the patient stated he had not been taking this medication since March 2007 at the direction of his physician.  - The plan of care included a multivitamin daily, however, the patient stated he had not been taking this medication for the past 3 months  - The plan of care included mylicon every hour of sleep, however, the patient stated he had not taken this medication since 2007 at the direction of his physician.		Canasa - discontinued as of 02/07/09 Caltrate - discontinued as of 02/07/09 Cymbalta - as of 02/07/09, correct dose is 30 mg TID po Desyrel - confirmed with spouse that patient continues to take 50 mg po hs Fosamax - confirmed with spouse that patient continues to take 70 mg po once per week every Monday Multivitamin - confirmed with spouse that patient continues to take one tab daily po Mylicon - confirmed with spouse that patient continues to take 80 mg daily po	

accepted 4/30/09  
JL Demetriu

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G 159 Continued From page 19

- The plan of care included neurontin 1200 mg 3 times per day, however, the patient stated he has been taking 1800 mg 2 times per day as directed by his physician.

- The plan of care included vitamin D every day, however, the patient stated he had not taken this medication for 3-4 months.

-The plan of care included flomax 0.4 mg every hour of sleep, however, the patient stated he is taking 0.8 mg every hour of sleep at the direction of his physician.

- The plan of care included vitamin B12, however, the patient stated he had not been taking this for 3 months.

- The patient stated he was taking 2 aleve tablets per day as needed for knee pain, however, this was not on the plan of care.

- The patient stated he began taking clonidine twice daily, 2-3 months ago, however, this is not on the plan of care.

- The patient stated he began taking lisinopril 2 twice daily, 2-3 months ago, however, this was not on the plan of care.

The patient record was reviewed with the DPS and Supervisor of Therapy and Intake on 03/09/09. No additional information was provided.

2. Patient #7 was admitted to the agency on 02/20/09. The 02/20/09 plan of care documented that the Licensed Home Care Agency (LHCSA)

G 159

Neurotin - dose ordered by physician was 1200 mg TID po but patient has been taking 1800 mg BID po, agency spoke with physician who approves dose and frequency preferred by patient and supplemental order completed.  
Vitamin D - discontinued 02/07/09  
Flomax- confirmed with spouse that patient takes 0.4 mg po hs  
Vitamin B12 - confirmed with spouse that patient continues to take 1000 mcg daily po  
Aleve - obtained physician order and now listed on agency's medication profile - two tabs po prn pain at hs, per spouse, patient takes 2-5 times per week  
Clonidine - new medication as of 03/06/09 - 0.2 mg daily po  
Lisinopril - new medication as on 06/06/09 - 20/25 mg BID po.

*Accepted 4/30/09  
JH DeMartino*



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G 159 Continued From page 20

nurse, contracted by the agency, would be managing the peripherally inserted central catheter (PICC), including flushing with normal saline and dressing changes. The plan of care failed to include:

- a complete plan for the PICC line. Specifically, the plan failed to specify: the type or frequency of the dressing; a plan to assess for PICC line migration, specifically a plan to measure the external length of the PICC line catheter; a plan to assess the PICC line site; flush the PICC line with 10 cc normal saline before and after the administration of the vancomycin per the 02/20/09 LHCSA nursing note; the PICC line was a double lumen catheter per the 08/15/09 initial CHHA nursing assessment; the purple lumen should be used for medication administration per the 02/21/09 and 02/27/09 LHCSA nursing notes; the vancomycin should be mixed in 200cc D5W and infused over 1 hour, per the 02/20/09 and 02/21/09 LHCSA nursing notes.

- a plan for the tracheostomy. Specifically, the plan of care documented the patient and his daughter managed the care of the tracheostomy, however, the plan failed to specify what the care included.

- a plan for the indwelling urinary catheter. Specifically, the plan of care documented the patient's daughter and private aide would manage the urinary catheter, however, the plan failed to specify what the care included.

The patient record was reviewed with the DPS on 03/10/09 and 03/12/09. No additional information was provided.

G 159

2. Patient #7: PICC line was discontinued as of 03/11/09 and therefore no further orders needed for care of PICC line. RN Case Manager has had a discussion with patient's daughter, who is a nurse practitioner regarding the specific care of patient's tracheostomy and a supplemental physician order has been completed outlining the tracheostomy plan of care and noting that care is provided by the patient's daughter and privately hired aide. Orders now also complete for the indwelling urinary catheter.

Clinical Team  
Leader 04/10/09

*Accepted 4/30/09*  
*H. DeMantano*

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G 159 Continued From page 21

3. Patient # 10 was admitted to the agency on 11/18/08. The 01/17/09 plan of care included a secondary diagnosis of mild retardation, and sliding scale for insulin 3 times per day. The 01/17/09 plan of care failed to include:

- an accurate diabetes management plan. Specifically the plan of care included that the pharmacy is pre-filling syringes for the regular dose of insulin to be administered at every hour of sleep, however, the plan failed to specify who is responsible for drawing up the sliding scale insulin syringes.

Additionally, there were 17 discrepancies between the 1/17/09 recertification nursing assessment and the 01/17/09 plan of care, for insulin doses, on the insulin sliding scale. For example the lunch and dinner insulin sliding scale doses included the following discrepancies:

The plan of care documented that for the lunch dose, if the blood glucose level is 111-140, then 19 units of insulin should be given. The nursing assessment, however, indicated 21 units should be given.

The plan of care documented that for the lunch dose, if the blood glucose level is 291-320, then 25 units of insulin should be given. The nursing assessment, however, indicated 27 units should be given.

The plan of care documented that for the dinner dose, if the blood glucose level is 60-80, then 22 units of insulin should be given. The nursing assessment, however, indicated 28 units should be given.

The plan of care documented that for the dinner dose, if the blood glucose level is 201-230, then 30 units of insulin should be given. The

G 159 3. Diabetes management plan for Patient # 10 has been reviewed by RN Case Manager and now specifies that client is capable and responsible to draw up own sliding scale insulin syringes. Agency is working with point of care system vendor regarding the problem with sliding scale insulin order discrepancies noted by DOH surveyor on the comprehensive assessment as compared to the POC. Problem is that insulin orders changed at a date later than the original POC and the comprehensive assessment, when printed at the time of DOH survey, reflected a newer set of orders than the POC of the same dates.

With respect to patient's psoriatic wounds - since the date of DOH visit, patient has been evaluated by WOCN (Wound Ostomy Continence Nurse) and RN Case Manager has had further conversations with patient's dermatologist so documentation is now more comprehensive and wound care plan is more specific. Aide service orders were changed from PCA 2 hours 3 X week to PCA 1 hour 3 X week and HHA 1 hour 3 X week. HHA Care Plan orders HHA to assist patient to apply overall skin moisturizers to intact skin, assist patient to apply prescribed lotions to stable wound areas patient cannot physically reach and to cue patient to complete rest of wound care regime as ordered by dermatologist. Improved patient compliance has been noted. Physician order has now been obtained to clarify that SN frequency is every 2 weeks instead of 2 X month.

Clinical Team  
Leader 04/10/09

*Accepted 4/30/09*  
*A. DeMartino*

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/12/2009
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NAME OF PROVIDER OR SUPPLIER

EAL SENIOR LIVING CTR LTHCP

STREET ADDRESS, CITY, STATE, ZIP CODE  
508 HIGH AVENUE  
ENDICOTT, NY 13760

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G159

Other patients listed with G 159:

Patient #2 - Issue per DOH surveyor verbal feedback related to peritoneal and hemodialysis catheter sites. see G 143, example #3

Patient #4 - Per DOH surveyor verbal feedback during survey, Lasix 20 mg daily po appeared to be new medication on 09/05/08 and agency records revealed no additional documentation regarding this new medication. Agency's Medication Management and Reconciliation procedures have been revised and staff have received inservice education See G 159

Patient #5

Patient #8 - DOH surveyor verbal feedback during survey related to assessment of endocrine system. See G 143, example #1

Patient #9 - Per DOH surveyor verbal feedback during survey, nursing documentation unclear regarding patient's safety at home related to cognitive issues and non-compliance issues. RN Case Manager and MSW have completed a case conference to discuss safety issues and MSW continues to follow patient monthly and prn. Nursing is assessing safety at every visit and safety assessments are included on patient's newly developed Problem List.

DPS - 04/24/09

Patient discharged from agency on 02/10/09.

Clinical Team  
Leader 04/17/09

accepted 4/30/09 22A  
L. Demetriou

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		3159	<p>Patient #11 - Per DOH surveyor verbal feedback during survey, SN visits ordered every week and occurring consistently every 7 days. SN visits are now scheduled and occurring every 7 days.</p> <p>Patient #12</p> <p>Patient #13</p>	<p>Clinical Team Leader 04/17/09</p> <p>Patient discharged from agency on 04/09/08.</p> <p>Patient discharged from agency on</p>
			Accepted 4/30/09 J De Martine	

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G 159	Continued From page 22 nursing assessment, however, indicated 33 units should be given.  - a wound care plan for the psoriatic wounds identified by the SN on the 01/16/09 recertification assessment.  - a specific plan for SN assessment frequency. Specifically, the 01/16/09 plan of care included SN visits 2 times per month, rather than every 2 weeks, and the SN failed to visit the patient for 20 days, from 01/06/09 to 01/26/09.  The patient record was reviewed with the DPS on 03/10/09. The DPS stated she was aware the plans of care for SN assessment frequency should be more specific, however, their software has prevented them from developing more accurate plans.	G 159		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE  Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.  This STANDARD is not met as evidenced by: Based on a review of 13 clinical records, and interviews with the Director of Patient Services (DPS), evidence is lacking in 8 records that the physician is consulted when changes in the patient condition occur. Patients # 1, 2, 3, 7, 9, 10, 12, 13  Failure to consult with the physician when changes in the patient's condition occur has resulted in a negative outcome for patient #7, and has the potential for unmet patient needs and	G 164	see pg 23A accepted 4/30/09 H. Denardine	

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G164

**Nursing Supervision:** Agency has identified need to increase supervision of care provided by field nurses and this will include the following actions:

1. Formal Case Conferences - see G 144
2. Increased frequency of field supervision: all nurses will be supervised in the field at a frequency of every 3 months over the next 6 months and then no less frequently than every 6 months on an ongoing basis. All nurses new to the agency will be supervised monthly for the first three months of their employment, during the sixth month of employment and then every 6 months on an ongoing basis. The supervising nurse will complete a field supervision assessment tool, review the findings with the field nurse, forward the completed tool to the DPS for review and sign-off and then this tool will then be filed in the field nurse's department file.

Begin Field Supervisions

3. Clinical Team Leaders will meet monthly on an individual basis with each field nurse they supervise to review client visits the field nurse has done over the past month and discuss patient status, specific care issues and performance areas that require improvement. The Clinical Team Leader will keep a supervisor's file for each field nurse and document the areas covered and any counseling/ coaching completed during the monthly meeting.

Begin monthly meetings.

Clinical Team  
Leaders and  
QI/Educ  
Coordinator  
04/20/09

Clinical Team  
Leaders 05/01/09

accepted 4/30/09  
J. Demarino

434

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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		G164	<p><b>4. Nursing Hand-Off Guidelines:</b> In order to coordinate comprehensive and quality care of our home care clients, Ideal Home Care expects that an appropriate hand-off of information will occur between the Office RN Case Manager and the per visit nurses.</p> <p>I. RN Case Manager to Per Visit Nurse</p> <ul style="list-style-type: none"> <li>When making visit assignments, the RN Case Manager will identify on the visit schedule the type of nursing visit being assigned and any specific clinical task needed to be completed for each visit. For example - pra visit, OASIS visit and type of OASIS, CASA Reauthorization visit, medisorter, foley catheter change, Vit B12 Injection, specific lab work, etc).</li> <li>It is expected that for all per visit nurses utilizing the agency's point of care system, the per visit nurse will review the following information either prior to making the home visit or while in the client's home in order to have updated information the nurse needs to complete a comprehensive nursing visit: <ul style="list-style-type: none"> <li>Multi-Disciplinary Prob List</li> <li>Medication Profile</li> <li>Last (1-3) Nursing Visit Notes</li> </ul> </li> <li>For nurses utilizing paper documentation, the RN Case Manager will need to provide the per visit nurse with hard copies of the Multi-Disciplinary Problem List, the Medication Profile, and 1-3 nursing visit notes.</li> <li>Additionally for all clients that are exceptionally complex or have had recent major changes in status, it may be necessary for the RN Case Manager to provide a verbal report to the per visit nurse prior to the visit and/or additional written information.</li> </ul>	

accepted 4/30/09  
J. Roman

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G164

II.

## Per Visit Nurse to RN Case Manager

It is the responsibility of the per visit nurse to review their client visit assignment each day and request additional client specific information from the RN Case Manager if there are any questions about the specific client visits they have been assigned.

By the end of the work day, the per visit nurse will report back to the RN Case Manager, either in person or via telephone or voice mail message, the findings and outcomes of each client visit completed that day. It is recommended that the per visit nurse include on their report, the information outlined in the Hand-Off Report which can be used as guide for reporting.

DPS 04/13/09

5. Performance evaluations as per the policy of Ideal Senior Living Center - all new employees are on probation for the first 6 months of employment and receive a probationary performance at the end of this 6 months and then annually during the first quarter of every calendar year. Annual Performance evaluations completed.

DPS 05/01/09

Staff Education and Inservices: Nursing Supervision including hand-off guidelines (see above); Comprehensive Pain Assessment, Management, and Documentation; Agency Parameters for Reporting patient status changes to the Physician; and Effective Communication with Physician including reporting change in patient status.

QI/Educ  
Coordinator and  
DPS 04/24/09

Accepted 4/30/09  
H. Dammann



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G164

**Comprehensive Audits and Plan of Care****Audits:** see G 143

**Pain Focus Audits:** Monthly focus audits (10 per month) will be completed to assess agency compliance with pain assessment and management. Audits will continue monthly until agency reaches a compliance threshold of 95% and then need will be re-evaluated if agency determines continued improvement still needed in agency outcomes.

Development of pain focus audit tools and procedures and train staff.

Implement pain focus audits.

See G 250 for more details on QI program.

QI/Educ  
Coordinator -  
05/15/09

QI/Educ  
Coordinator -  
05/18/09

*Accepted 4/30/09  
JL De Martine*

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G 164	Continued From page 23 agency wide negative patient outcomes.  Examples are as follows:  1. Patient # 7 was admitted to the agency on 02/20/09. The plan of care included percocet 1-2 tabs every 4 hours as needed for pain, and a duragesic transdermal patch 25 mcg, to be changed every 3 days. The Skilled Nurse (SN) failed to report the patient's pain to the physician, and failed to advocate for an adequate pain management plan for the patient, which resulted in the patient suffering uncontrolled pain for 10 days as follows:  - Between the dates of 02/20/09 and 03/02/09, the SN assessed eleven times that the patient's pain level was greater than 8 out of 10. During the same time period the SN documented 6 times that the daughter was going to call the physician for new pain medication. Evidence is lacking the patient's unrelieved pain was ever reported to the physician by the SN. The SN failed to understand that it is her responsibility to report changes in patient condition to the physician, and advocate for an effective pain management plan for the patient.  - Additionally, evidence is lacking the SN ever assessed and reported to the physician the integrity of the duragesic patch, or the frequency, and dosage with which the patient was taking the percocet, and the plan of care failed to include the percocet dosage.  - On 02/27/09 the SN visited the patient and documented the patient was trying vicodin and ibuprofen for pain. The SN, however, failed to specify the dose of these medications, or obtain a	G 164	1. Review of recent SN visits for patient #7 indicate improvement in SN assessment and documentation of pain and communication with physician with respect to patient's pain management. On 3/30/09, patient reports pain level of 3 out of 10 and states "pain medications are helping." On 03/19/2009, RN discussed patient's level with physician who stated that he had educated patient that his pain level of recent weeks was to be expected during the post-op period and that over time, level of pain would improve. Medications for pain: Duragesic patch 25 mcg - change every 3 days and Percocet 1-2 tabs every 4 hours po prn for break-thru pain. Nursing has continued to teach and reinforce appropriate use of pain medications and assesses pain status as very skilled nursing assessment.	Clinical Team Leader 04/10/09

Accepted 4/30/09  
H. DeMarino

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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G 164 Continued From page 24  
physician order, and on 02/28/09 the SN  
documented that the patient's pain level  
continued at a level of 8 out of 10.

The patient record was reviewed with the DPS on  
03/10/09. No additional information was provided.

2. Patient #3 was admitted to the agency on  
07/11/08. The SN failed to report the following  
changes in patient condition to the physician as  
follows:

- On 12/19/08 the SN visited the patient and  
documented the patient was experiencing  
vomiting and diarrhea for the prior 2 days, and  
had vomited a large amount of brown liquid  
during the visit. Evidence is lacking this was  
reported to the physician.

- On 01/04/09 the SN visited the patient and  
documented: the patient had a sinus infection, the  
physician prescribed antibiotics, the wife had not  
yet filled the prescription, the SN was uncertain as  
to the type of antibiotics, the patient had an acute  
cough with yellow/brown sputum, the patient was  
not sleeping well. Although the SN phoned the  
physician for authorization to continue the home  
care services, evidence is lacking the SN  
reported the patient symptoms to the physician,  
or obtained a verbal order for the antibiotics.

The patient record was reviewed with the DPS  
and Intake and Therapy Supervisor on 03/09/09.  
No additional information was provided.

3. Patient # 10 was admitted to the agency on  
11/18/08. The SN failed to report increasing  
lower leg edema to the physician as follows:

2. Patient #3 - no further s/sx or  
complaints of vomiting, diarrhea, or  
respiratory problems have been noted.

Clinical Team  
Leader 04/10/09

*Accepted 4/30/09  
H DeMottine*

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G 164	<p>Continued From page 25</p> <p>- On 01/16/09 the SN documented the following edema measurements: right ankle was 34.5 cm. left ankle was 29 cm. left calf was 57 cm. The SN failed to measure the patient's right calf or bilateral instep.</p> <p>- On 1/26/09 the SN assessed both the patient's right and left legs as + 2. Evidence is lacking the SN measured the patient's leg, and consequently was unable to compare her assessment to the previous assessment.</p> <p>- On 2/16/09 the SN documented the following edema measurements: right ankle was 37.5 cm, representing an increase of 3 cm from 1/16/09. left ankle was 35 cm, representing an increase of 6 cm. from 1/16/09. left calf was 62 cm, representing an increase of 5 cm. from 1/16/09. right and left insteps as 5 cm, the right calf as 57 cm. The SN had failed to previously take these measurements.</p> <p>Evidence is lacking any of the above measurements were reported to the physician.</p> <p>The patient record was reviewed with the DPS and Intake and Therapy Supervisor on 03/09/09. No additional information was provided.</p>	G 164	<p>3. Patient #10 - improved assessment and documentation of patient's edema has been noted and RN Case Manager has been counseled to report changes in patient's edema to physician. Agency's record indicates patient was diagnosed with Chronic Edema in 1975. Nursing assessments note that edema has been stable at 2+ of bilateral lower extremities. Nursing documents ongoing education of patient re: elevation of legs and compliance with Lasix 80 mg daily po. Physician is aware and has made no changes to POC. Agency policy with respect to edema is for nurses to assess and document edema as pitting vs non-pitting and using scale of 1+ - 4+ for pitting edema. Nurses for patient #10 have been counseled regarding agency policy and patient's Problem List notes that patient has chronic edema and cues nurses re: agency policy for assessment and documentation of this edema.</p>	Clinical Team Leader 04/24/09
G 171	<p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse makes the initial evaluation visit.</p>	G 171	<p>See page 269 for other patients listed G 164...</p> <p>accepted 4/30/09 H. K. [Signature]</p>	

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G164

Other patients listed with G 164:

Patient #1 - DOH surveyor verbal feedback during survey related to patient's level of pain and comprehensive pain assessments. See G 172, example #3

Patient #2 - Per DOH surveyor verbal feedback during survey, patient was in the Emergency Dept on 02/10/09 for hypoglycemia and evidence is lacking that during a SN visit post ED visit, that the nurse reported patient's in home blood sugar reading of 67 and discussed possible need for a change in the POC. Staff have received inservice education about effective communication with physicians and reporting changes in patient status including possible need to alter POC.

Patient #9 - DOH surveyor feedback during survey was related to documented changes in patient's weight. See G158, example #1

Patient #12

Patient #13

DPS - 04/24/09

Patient  
discharged from  
agency on  
04/09/08.  
Patient  
discharged from  
agency on  
02/11/09.

accepted 4/30/09  
A Demarchus

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G 171

Continued From page 26

This STANDARD is not met as evidenced by:  
Based on a review of initial nursing assessments  
in 6 clinical records (patients # 2, 5, 6, 7, 9, 12),  
and interviews with Director of Patient Services  
(DPS), evidence is lacking in 3 records the initial  
nursing assessments are of sufficient scope to  
ensure that all patient needs are met. Patients #  
2, 7, 12

Lack of complete and accurate nursing  
assessments has the potential for unmet patient  
needs and possible negative patient outcomes.

Examples are as follows:

1. Patient # 12 was an [REDACTED] admitted  
to the agency on 12/18/07. The plan of care  
documented the patient was non ambulatory.  
The 12/18/07 initial nursing assessment failed to  
include the patient's ability to transfer.  
Specifically, the SN documented the patient and  
son reported the patient required the assist of 1  
person to transfer; however, evidence is lacking  
the SN actually observed the patient's ability to  
transfer safely.

On 12/19/07 a phone call was documented from  
the aide to report to the SN the patient was on the  
commode, and she (the aide) could not transfer  
him off. The SN directed the aide to call the local  
fire department for assistance.

Additionally, although the SN documented the  
patient reportedly needed only the assist of 1  
person to transfer, the SN also documented the  
patient had a hooyer lift. On the following day,  
12/19/07, the Physical Therapist (PT)  
documented that the patient did not yet have the  
hooyer lift.

G 171

Nursing Supervision: see G 164  
Problem List Development: see G 143  
Comprehensive Audits and Plan of Care  
Audits: see G 143 See G250 for more  
details re: QI Program  
Developing the Plan of Care Policy:  
Agency will review/revise policy on  
developing the client plan of care.  
Staff Education: Developing the POC

DPS 05/15/09  
DPS and  
QI/Educ  
Coordinator  
05/29/09

1. Patient # 12 was discharged from  
agency on 04/09/08.  
RN who completed the initial  
assessment for this client was  
counseled/coached regarding the need  
to comprehensively assess a client's  
functional status before an accurate  
aide care plan can be developed.

Completed  
12/28/2007 by  
DPS

*Accepted 4/30/09*  
*A. DeMartino*

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NAME OF PROVIDER OR SUPPLIER

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STREET ADDRESS, CITY, STATE, ZIP CODE  
508 HIGH AVENUE  
ENDICOTT, NY 13760

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G 171

Continued From page 27

The patient record was reviewed with the DPS on 03/12/09. No additional information was provided to explain the inconsistent information.

2. Patient # 7 was admitted to the agency on 02/20/09 with a secondary diagnosis of diabetes. The 02/20/09 plan of care included intravenous vancomycin 1 Gm every 12 hours via a peripherally inserted central catheter (PICC) line, and that the patient was using the glucometer as prescribed by the physician, and was testing his glucose once per day. The 02/20/09 initial nursing assessment was incomplete as follows:

- The SN documented that the patient was discharged from the hospital that day following surgery on his left knee to remove an infected knee prosthesis. The SN documented that the wound was closed, however, she could not observe the incision because the patient was wearing a brace. It is unclear how the SN knew the wound was closed, and evidence is lacking she contacted the physician to discuss: if the brace could be removed, what the wound status was, or if a wound care plan was needed.

- Evidence is lacking SN assessed the PICC line site, if the patient had a single or double lumen PICC line, whether the vancomycin was infusing during the visit.

- Evidence is lacking the SN observed if the patient could demonstrate the use of the glucometer, or if the patient had a functioning glucometer in the home.

The patient record was reviewed with the DPS on

G 171

2. Patient #7 - PICC line was discontinued 03/11/09 and surgical wound is now healed. Patient has a functioning glucometer in the home and SN has observed and documented that patient can use his glucometer effectively.

Clinical Team  
Leader 04/10/09

*Accepted 4/30/09*  
*At Demantwe*

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G 171	Continued From page 28 03/10/09, no additional information was provided.  3. Patient # 2 was admitted to the agency on 01/27/09. The 01/27/09 initial nursing assessment documented the patient had a peritoneal dialysis catheter, which was covered with a 4 x 4 dressing. Evidence is lacking the SN ever assessed the peritoneal dialysis site.  Additionally, the SN documented the patient was experiencing daily aching pain of the left leg at a level of 5 that was not easily relieved. The SN also assessed that the pain was relieved with tylenol, however, failed to assess the frequency with which the patient was taking the tylenol, and the plan of care does not include a frequency or maximum daily dosage for the tylenol.  The patient record was reviewed with the DPS and Therapy and Intake Supervisor on 03/09/09. No additional information was provided.	G 171	3. For patient #2 - peritoneal dialysis catheter has been discontinued as of 03/6/09. Leg pain reported to be 6 out of 10 on 3/17/09. On this same date, patient filled a new prescription for Hydrocodone 7.5/750 mg and has been taking this medication prn for break thru pain when Tylenol is not effective. Skilled nursing assessments on 3/30/09 and 04/07/09 indicate that patient reported a pain level of "0" out of 10. Comprehensive pain assessments now being completed and documented and a physician order has been obtained for a maximum daily dose of Tylenol.	Clinical Team Leader 04/10/09
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse regularly re-evaluates the patients nursing needs.  This STANDARD is not met as evidenced by: Based on a review of 13 clinical records, and interviews with the Director of Patient Services (DPS), evidence is lacking in 6 records the Skilled Nursing (SN) assessments are of sufficient scope to identify changes in the patient's condition which may require re-evaluation and/or modification in the plan of care. Patients # 1, 2, 3, 6, 8, 13  Failure to perform complete and accurate nursing assessments has the potential for unmet patient	G 172	see pg 29A  see pg 29B  Accepted 4/30/09 H DeMaurice	



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		G171		

Other patients listed with G 171:

Patient # 5

Patient # 6 - Per DOH surveyor verbal feedback during survey, patient's medication profile listed Coreg twice - once as discontinued and once as an active medication. This issues has been discussed with the physician and agency has received clarification that patient is to continue Coreg 12.5 mg po BID.

Patient #9 - DOH surveyor feedback during surveyor was related to documented changes in patient's weight. See G158, example #1

Patient  
discharged from  
agency on  
02/10/09

Clinical Team  
Leader 04/22/09

*accepted 4/30/09  
J. DeMarino*

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			<p>G 172</p> <p><u>Staff Education:</u> Discussion with and education of nursing staff with respect to use of point of care system's choices of "consult indicated" vs "no problems requiring intervention". Agency's policy will be that in many cases, neither option is an appropriate selection and in many assessment areas, the nurse must write a narrative in order to fully present an accurate and comprehensive picture of patient's status or situation. Nursing staff have been educated that this level of documentation must be completed for every comprehensive assessment even for a long term chronic patient so that a clear and comprehensive picture of patient's situation is documented. Staff also educated regarding need to report all changes in client status promptly to physician including need to discuss with the physician possible need for POC changes such as a change in frequency of skilled nursing assessments.</p> <p><u>Nursing Supervision:</u> see G 164</p> <p><u>Problem List Development:</u> see G 143</p> <p><u>Comprehensive Audits and Plan of Care Audits:</u> see G 143 See G250 for more details re: QI Program</p> <p>Accepted 4/30/09 H. Romanini</p>		QI/Educ Coordinator and DPS 04/24/09

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G 172	<p>Continued From page 29</p> <p>needs, and possible negative patient outcomes.</p> <p>Examples are as follows:</p> <p>1. Patient # 8 was admitted to the agency on 7/16/99. The 12/02/08 plan of care indicated that the patient had a history of urinary tract infections and had a foley catheter. The plan stated the SN was to change the foley catheter monthly and PRN. The SN assessments were inaccurate or incomplete as follows:</p> <ul style="list-style-type: none"> <li>- On 1/23/09 the Home Health Aide reported to the SN that she observed some "floaties" in the client's catheter bag and wondered if this should be assessed. On 1/23/09 the SN documented she called the patient to make an appointment for a home visit, that the patient refused, and asked for a visit on Monday 1/26/09. Evidence is lacking the SN visited the patient as planned, or that the physician was notified of the patient's change in condition.</li> <li>- On 1/27/09 a voice message was documented from the aide to the SN, and the aide requested that the SN assess the patient for signs and symptoms of a urinary tract infection on her (the SN's) scheduled visit for the following day. Evidence is lacking the SN visited until 01/28/09, which was 5 days following the first report of the patient's urinary symptoms.</li> <li>- On 2/23/09 the SN visited the patient and documented that she was to change the patient's catheter at that visit "due to the patient calling last week to report that her catheter was leaking urine". The SN failed to document the exact date the patient had phoned, and evidence is lacking the SN visited the patient until one week</li> </ul>	G 172	<p>1. Patient #8 - patient assessed by RN on 03/12/2009 and on that date did not have an active urinary tract infection or any signs or symptoms of an infection that would require intervention by the SN.</p>	<p>Clinical Team Leader 04/10/09</p>

*Accepted 4/30/09*  
*H. DeMarsh*

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G 172	<p>Continued From page 30</p> <p>after the patient's report of the leaking catheter.</p> <p>This record was reviewed with the Director of Clinical Services and the Therapy Intake Supervisor on 3/9/09. No new evidence was provided</p> <p>2. Patient #3 was admitted to the agency on 07/11/08. The SN failed to conduct reassessments as follows:</p> <ul style="list-style-type: none"> <li>- On 12/05/08 the SN documented the patient was experiencing rectal bleeding, and the physician ordered a CBC. The SN failed to revisit the patient until 9 days later on 12/14/08 to reassess the status of the patient's rectal bleeding.</li> <li>- On 12/19/08 the LPN visited the patient, and documented the patient had been experiencing vomiting and diarrhea for the prior 2 days, and that the patient had vomited during the visit. Although the LPN reported the symptoms to the RN, the RN failed to assess the patient until 7 days later on 12/26/09.</li> <li>- On 01/14/09 the SN visited the patient and documented the patient had a cough, which the SN reported to the physician. The physician directed that the patient be evaluated in the MD office or emergency room if the respiratory symptoms did not improve. The SN failed to reassess the patient until 22 days later on 02/07/09.</li> </ul> <p>The patient record was reviewed with the DPS and Intake and Therapy Supervisor on 03/09/09. No additional information was provided.</p>	G 172	<p>2. Patient #3 - Review of recent SN visits indicates that patient receiving SN visit every week as ordered and documentation indicates consistent assessment of patient's GI status including history of rectal bleeding. Patient has diagnosis of chronic GI bleeding with anemia and there have been no further episodes of bloody stools or rectal bleeding by the patient or his spouse. Patient continues to have weekly lab work done for CBCs and his H/H ranges from 01/2009 through 04/12/09 are 9.6-10.5/31.6-34. 4/12/2009 H/H results were 10/32.6 which is within a stable range for this patient. No further problems with vomiting, diarrhea, or respiratory symptoms have been reported or noted.</p>	Clinical Team Leader 04/17/09

*Accepted 4/30/09*  
*H De Martine*

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G 172

Continued From page 31

3. Patient # 1 was admitted to the agency on 09/26/08. The 01/21/09 SN assessment was incomplete or inaccurate as follows:

- The SN documented that the patient was experiencing constant sharp head/back/neck pain at a level of 8 out of 10, that was not easily relieved. The plan of care however, failed to include any pain medications. Evidence is lacking the SN assessed if the patient was taking any pain medications, or assessed for the need of a pain management plan, and instead assessed that there were "no problems requiring intervention".

- The SN documented the patient: was verbalizing negative feelings about himself due to increasing dependency on others, and that the patient was residing in an inadequate/crowded living space. The SN documented that there were "no problems requiring intervention," however, also documented "consider social work consultation". Evidence is lacking the SN identified that the patient was receiving social work services at the time, and failed to assess if the social work services were meeting the patient's needs.

The patient record was reviewed with the DPS and Therapy and Intake Supervisor on 03/09/09, no additional information was provided.

G 225

484.36(c)(2) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE

The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.

G 172

3. Patient #1 - medication reconciliation completed and medication profile updated to include patient's pain medications: Celebrex 200 mg daily po, Soma 350 mg TID po prn pain, and Tylenol #3 TID po prn pain. Patient currently reporting pain level of 4 out of 10 and reports pain managed with current medications. Nursing documents that patient not always compliant with use of his pain medications and re-reaching has been done. RN Case Manager has also spoken with patient's informal caregiver about use of pain medications for management and control of pain. On 03/30/2009, nursing discussed patient's pain level with the physician. RN Case Manager has met with MSW who notes that patient has history of depression but no s/sx that depression is an active problem currently. RN Case Manager and MSW made joint home visit to address patient's current living environment with patient's informal caregiver.

Clinical Team  
Leader 04/10/09

G 225

see pg 37A

accepted 4/30/09  
H Demantre

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		G172		

Other patients listed with G 172:

Patient # 2 - Issue per DOH surveyor verbal feedback related to peritoneal and hemodialysis catheter sites. see G 143, example #3

Patient # 6 - Per DOH surveyor verbal feedback during survey, patient's medication profile listed Coreg twice - once as discontinued and once as an active medication. This issue has been discussed with the physician and agency has received clarification that patient is to continue Coreg 12.5 mg po BID.

Patient #13

Patient  
discharged from  
agency on  
02/11/09.

Accepted 4/30/09  
H DeMethne

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225	Continued From page 32	G 225		
	<p>This STANDARD is not met as evidenced by: For 6 of 12 patients, where the agency was providing aide service, evidence is lacking the aide care plans were sufficient in scope to ensure the Personal Care Aides (PCA's) and Home Health Aides (HHA's) were clear in their duties, and were acting within their scope of practice per the New York State Department of Health January 2007 Home Health Aide Scope of Tasks, and the New York State Department of Social Services December 1, 1994 Level 1 and 2 Personal Care Aide Scope of Functions and Tasks. Patients # 6, 3, 8, 9, 11, 13.</p> <p>Failure of the agency to ensure that the care provided by all personnel is permitted under state law, has the potential for unmet patient needs, and possible agency wide negative patient outcomes.</p> <p>Examples are as follows:</p> <p>HV</p> <p>1. Patient # 3 was admitted to the agency on 07/11/08. Although the patient record included separate care plans for the PCA and HHA, the surveyor conducted an observational home visit on 03/06/09, and only one care plan for both the PCA and HHA was in the patient's home. The plan included a home exercise program, which is beyond the scope of tasks for the PCA.</p> <p>The patient record was reviewed with the DPS and Intake and Therapy Supervisor on 03/09/09. No additional information was provided.</p> <p>2. Patient # 2 was admitted to the agency on 01/27/09. The 01/27/09 care plan failed to specify</p>	G 225	<p><u>Aide Care Plan Policy Revision:</u> Revise aide care plan policy to indicate that agency will write a separate aide care plan for each level of aide assigned to a patient and that all aide care plans will be updated every 60 days.</p> <p><u>Staff Education:</u> Aide Care Plans and review of Scope of Practice for each aide level (e.g. HHA, PCA).</p> <p><u>Aide Care Plan Focus Audits:</u> See G 158</p>	DPS 04/13/09 QI/Education Coordinator and Aide Supervisor 05/29/09
			<p>1. Aide care plans for patient # 3 now updated to include a separate aide care plan for the PCA and HHA and current aide care plans have been placed in the patient's home.</p>	Clinical Team Leader 04/10/09
			<p><i>Accepted 4/30/09</i> <i>H. Demartino</i></p>	

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G 225	Continued From page 33 which tasks were for the PCA and which were for	G 225		
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which tasks were for the PCA and which were for the homemaker. The plan included reminding the patient to take medications, reminding the patient to check blood sugars, bathing and shampooing the patient. These tasks are only within the scope of tasks for a PCA, and the PCA care plan failed to include these tasks.

The patient record was reviewed with the DPS and Intake and Therapy Supervisor on 03/09/09. No additional information was provided.

3. Patient # 11 was admitted to the agency on 01/12/09. The 11/05/08 care plan indicated the homemaker was to prepare no concentrated sweet meals, remind the patient to take medications, and test the personal emergency response system (PERS) system monthly. This is only within the scope of tasks for a PCA, and the PCA care plan failed to include these tasks.

The patient record was reviewed with the DPS on 03/11/09. No additional information was provided.

**484.52(b) CLINICAL RECORD REVIEW**

At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.

This STANDARD is not met as evidenced by:  
Based on a review of: the agency's policies and procedures, quality assurance program, Professional Advisory Committee (PAC) and Governing Body meeting minutes for the past 12 months, and interviews with the Director of

G 225

2. Patient #2 - aide care plan now updated with separate aide care plans for PCA and homemaker which indicate appropriate tasks within scope of each level of aide.

**Clinical Team  
Leader 04/10/09**

3. Patient #11 - Aide care plans updated for separate aide care plans for each level of aide and tasks of meal preparation of NCS diet and the testing of the PERS unit have been delegated to the PCA level of aide.

Clinical Team  
Leader 04/10/09

**G 250**

see pg 35

Accepted 4/30/09  
H. Remarking



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G125

Other patients listed with G 225:

Patient #6 - DOH surveyor verbal feedback during survey indicated that aide activity documentation did not accurately reflected aide tasks assigned on Aide Care Plan. See G125, example #1

Patient #8 - Per DOH surveyor verbal feedback during surveyor, aide documentation not reflecting consistent completion of assigned tasks of assisting client to shampoo hair, oral care and skin care. All aides have been counseled about the need to follow the Aide Care Plan and to document all tasks assigned on this Aide Care Plan when they complete their visit documentation. Aides have also received this direction in writing and have been required to sign off on this communication verifying their receipt and comprehension of this information.

Patient #9 - Per DOH surveyor verbal feedback received during survey, patient receiving two levels of aide service: HHA and PCA and agency was using only one care plan that did not clearly delineate HHA vs PCA tasks. Patient now has two updated Aide Care Plans which includes a separate Care Plan for each level of aide assigned.

Patient #13

Aide Supervisor  
04/16/09

Clinical Team  
Leader 04/07/09

Patient  
discharged from  
agency on  
02/11/09.

accepted 4/30/09  
H Re Martin

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/12/2009
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NAME OF PROVIDER OR SUPPLIER

IDEAL SENIOR LIVING CTR LTHHCP

STREET ADDRESS, CITY, STATE, ZIP CODE

508 HIGH AVENUE

ENDICOTT, NY 13760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 250	Continued From page 34  Patient Services (DPS), evidence is lacking the agency has a functional quality assurance / quality improvement program which has identified and corrected recurring systemic problems associated with the development and implementation of plans of care. Specifically:  1. Evidence is lacking the agency conducted any comprehensive audits of patient records since June 2008. As a result the agency failed to identify problems with: following the plans of care, developing accurate and complete nursing assessments, reporting changes in patient condition to the physician, as identified in this report. See G 159, G 164, G 172.  2. The Comprehensive audits conducted in the first 2 quarters of 2008 were narrow in scope, and identified only the absence or presence of information. The audits failed to identify problems with the quality of care. For example for the 2nd quarter of 2008, the audits showed the agency in 89% compliance with coordination of care, and failed to identify significant deficiencies with coordination of care, as identified in this report. See G 143  3. Although the agency conducted quarterly plan of care audits, at the start of care, the audits were narrow in scope, and identified only the absence or presence of information. The agency failed to include reviews of initial assessments, to assist in identifying plan of care problems. As a result, the agency failed to identify initial assessment, and plan of care deficiencies as identified in this report. For example, for the year of 2008, the agency audits showed that 77 - 100% of medication profiles were complete, however, significant issues with the accuracy of	G 250	<u>2009 Quality Improvement Program:</u> Agency's 2009 QI program will be revised to incorporate revised audit tools, additional focus audits to monitor activities related to this DOH Plan of Correction and need for staff education regarding completing an effective audit and use of audit tools. All levels of agency staff will be involved in conducting audits - from supervisors to peer level audits. Initially, all audits will be completed by agency supervisors and once supervisors are conducting effective audits and audit tools are tested, then front line staff will be trained in the audit process so that peer level audits are being done. This will include both professional and para-professional staff.  <u>Written Revision of 2009 QI Program:</u> written document to incorporate principles as above and will state that the agency will use audit outcomes from POC and Comprehensive Audits to continue to identify areas where performance improvement is needed and from these outcomes, additional focus audits will be developed with agency compliance threshold targets.  Revised QI Plan will be reviewed and approved by internal QI committee, PAC and Board QI committees. All committees have meeting dates before the end of May 2009.	QI/Education Coordinator and DPS - 05/01/2009  DPS 05/29/09

Accepted 4/30/09  
H. Demartino

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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		G150	All audit results will be analyzed, trended and outcomes will be shared with agency staff, agency's internal QI Committee, PAC and the Ideal Senior Living Center Board QI Committee. Meeting minutes of each committee will reflect the content presented, committee member discussion and the committee's recommendations for follow up.	QI/Education Coordinator, DPS, and President/CEO - May 2009 Committee meetings and then ongoing on a quarterly basis
			<u>Staff Education:</u> Outcomes of audits will determine need for additional staff education and inservices and this education will be developed and scheduled as needs are identified based on audit outcomes.	Clinical Team Leaders, QI/Education Coordinator, and DPS - Ongoing
			1. Agency will review/revise comprehensive audit tool and provide training to auditing staff with respect to use of the tool and how to complete an effective audit.	QI/Education Coordinator - 05/15/09
			2. Agency will initiate complete comprehensive audits. Overall compliance threshold target for comprehensive audits is 90%. See G 143	QI/Education Coordinator - 05/18/2008
			3. Plan of care audits - see G 143. Audit tools to be reviewed/revised and staff training will be completed. Audits - 100% of start of care and resumption of care and a minimum of 50 % of recertification audits. Overall compliance threshold target for plan of care audits is 90%.	QI/Education Coordinator - 05/15/09 QI/Education Coordinator - 05/18/09 and ongoing

Accepted 4/30/09  
H. R. Martin

65A

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G 250 Continued From page 35

medications on the plans of care were identified by this survey. See G 158, G 171.

4. Based on a review of PAC meeting minutes, and Governing Body meeting minutes for the past 12 months, evidence is lacking the PAC is making recommendations for a quality improvement plan to the governing body based on auditing results.

5. Although there is evidence that trended auditing results are being presented to the PAC and Governing Body quarterly the Quality Improvement Committee, evidence is lacking that a plan of action is being developed by the Governing body based on the Quality Improvement Committee results. For example, for the last 2 quarters of 2008, the QI committee reported to the PAC committee and Governing body, that due to vacant QI and Education Coordinator positions, and other "staffing challenges", the agency had been unable to perform any comprehensive chart audits since June 2008. Evidence is lacking the Governing Body developed and implemented a timely action plan to ensure that the agency continued to have a functioning quality assurance program.

On 03/12/09 the agency's quality assurance program was reviewed with the DPS. The DPS stated that the agency had not been able to conduct comprehensive audits of patient records for at least 6 months, however, the agency just filled the Quality Improvement Coordinator position. Additionally, the DPS stated that approximately 2 months ago, the agency "backed off" from auditing records at all starts of care, and resumption of care, and she is planning to reinstate this.

G 250

4. Professional Advisory Committee members will be educated about their role and responsibility with respect to the agency's QI program including the need to review the agency's QI Program and outcomes and make any recommendations they have to the Governing Body for changes to the agency's quality improvement program based on auditing results.

DPS - May 2009  
PAC Meeting -  
by 05/29/09

5. The Ideal Senior Living Center Board's QI Committee will be educated regarding the role and responsibility of the Governing Body with respect to the agency's QI program including their responsibility to ensure that the agency has a comprehensive functioning quality assurance program at all times.

President/CEO -  
May 2009 Board  
QI Committee  
Meeting - by  
05/29/09

*Accepted 4/30/09*  
*H. DeMandine*

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## New York State Department of Health

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7 100 Construction Standards - Ramp

7 100

The operator shall ensure that ramps are constructed to local standards.

This REQUIREMENT is not met as evidenced by:  
HV

Based on 1 of 1 observational home visits, where the services provided by the agency included the provision of a ramp, evidence is lacking the agency has a procedure in place to ensure that all construction, including the construction of ramps, adhere to local standards. Patient #3.

Specifically:

Patient #3 was admitted to the agency on 02/26/08, the initial plan of care documented that the patient had a secondary diagnosis of paraplegia, and that the patient was wheelchair bound. Evidence is lacking the agency ensured that a temporary ramp, which the patient had for at least 2 months, was constructed to local standards as follows:

- The 02/26/08 Department of Social Services (DSS) care plan documented that the agency would "look at getting estimates for a ramp", and the 03/18/08 social work evaluation documented the family would be having a ramp built on the home for patient. The Social Worker (SW), however, failed to document how, or when, the plan for the ramp would be implemented.

- On 04/04/08 the SW visited the patient and documented that she (the SW): would obtain an update from the Veterans Administration (VA) on the ramp, and she obtained a physician order for the rental of a temporary ramp through a vendor.

Agency will develop comprehensive QI Program for all waived services - see G 125.

Specifically re: Home Improvement Services - this will include a mechanism to assess the quality of all construction and that local standards are being met. Agency plans to work with local building code inspectors and/or the local Southern Tier Independence Center to develop this type of relationship and procedure for future construction projects. DPS will meet with Danny Cullen from the local Southern Tier Independence Center to discuss their role and oversight in construction projects.

Staff Education:

effective Home Care Documentation to include comprehensive documentation of case coordination of waived services.

DPS -  
05/29/2009

DPS -04/24/09

Patient #3 - Temporary ramp no longer being provided for this patient - permanent ramp was built by the VA and is now in place.

DPS 10/31/2008

*Accepted 4/24/09  
H. DeMantone*

Office of Health Systems Management / Office of Long Term Care

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

Version 09/12/08

0069

G0US11

If continuation sheet 1 of 2

## New York State Department of Health

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

IDEAL SENIOR LIVING CTR LTHHCP

508 HIGH AVENUE  
ENDICOTT, NY 13760

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7 100	<p>Continued From page 1</p> <p>the SW failed to assess what the patient's safety status was from 02/26/08 to 04/04/08, specifically, how the patient was able to enter and exit his home during this time period.</p> <p>- On 04/25/08 the SW documented a phone call from the VA indicating they approved the construction of a permanent ramp, however, evidence is lacking the SW documented when the permanent ramp was installed.</p> <p>On 03/06/09 an observational home visit was conducted by the surveyor, and a permanent ramp was visible from the patient's driveway to the front entrance of his home. The patient and wife told the surveyor that they were satisfied with the current ramp provided by the VA, and that they were unsure of when the permanent ramp was installed. The patient and wife, however, told the surveyor that the temporary ramp, which had previously been installed by the agency "was a joke". They described it as going straight up the stairs, and stated it was unusable due to the sharp incline.</p> <p>The patient record was reviewed with the DPS on 03/09/09. The DPS told the surveyor that the agency has no mechanism in place to ensure that local construction codes are adhered to for ramp construction, or that patients are satisfied with the installation.</p>	7 100		

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NAME OF PROVIDER OR SUPPLIER  GENTIVA HEALTH SERVICES BINGHAMTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1249 FRONT STREET, SUITE 110 BINGHAMTON, NY 13905
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G 000	<p>INITIAL COMMENTS</p> <p>This statement of deficiencies is the result of a recertification survey and on site investigation of complaint # NY00070259 initiated on 04/06/09. On 04/08/09 deficiencies were identified with nursing services and the survey was expanded to a partial extended survey.</p> <p>The survey consisted of a review of 19 clinical records, 7 of which included observational home visits, and 15 personnel records. Interviews were conducted with the Area Vice President, Agency Administrator, and Director of Patient Services (DPS). Additionally reviewed were agency: clinical and administrative policies and procedures, OBQI Adverse Event Outcome Report for the period of October 2008 - December 2008, emergency preparedness plan, Complaint Investigation Log, On Call Log, Governing Body minutes, Professional Advisory Committee minutes and quality assurance program activities for the most recent 12 months.</p> <p>Throughout the survey, each clinical record chosen as part of the sample was reviewed with the DPS.</p>	G 000		
G 116	<p>484.10(f) HOME HEALTH HOTLINE</p> <p>The patient has the right to be advised of the availability of the toll-free HHA hotline in the State.</p> <p>When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use</p>	G 116		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kathleen Rogers RN

Branch Director

6-8-09

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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G 000	<p><b>INITIAL COMMENTS</b></p> <p>This statement of deficiencies is the result of a recertification survey and on site investigation of complaint # NY00070259 initiated on 04/06/09. On 04/08/09 deficiencies were identified with nursing services and the survey was expanded to a partial extended survey.</p> <p>The survey consisted of a review of 19 clinical records, 7 of which included observational home visits, and 15 personnel records. Interviews were conducted with the Area Vice President, Agency Administrator, and Director of Patient Services (DPS). Additionally reviewed were agency: clinical and administrative policies and procedures, OBQI Adverse Event Outcome Report for the period of October 2008 - December 2008, emergency preparedness plan, Complaint Investigation Log, On Call Log, Governing Body minutes, Professional Advisory Committee minutes and quality assurance program activities for the most recent 12 months.</p> <p>Throughout the survey, each clinical record chosen as part of the sample was reviewed with the DPS.</p>	G 000			
G 116	<p><b>484.10(f) HOME HEALTH HOTLINE</b></p> <p>The patient has the right to be advised of the availability of the toll-free HHA hotline in the State.</p> <p>When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use</p>	G 116			

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TITLE

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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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GENTIVA HEALTH SERVICES BINGHAMTON

STREET ADDRESS, CITY, STATE, ZIP CODE

1249 FRONT STREET, SUITE 110

BINGHAMTON, NY 13905

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G 116	Continued From page 1 this hotline to lodge complaints concerning the implementation of the advanced directives requirements.  This STANDARD is not met as evidenced by: Based on a review of 19 clinical records, review of the agency's admission packet, and staff interviews, evidence is lacking the agency advised all patients of the availability of the toll-free Home Health Agency hotline established by New York State for patient questions and complaints. Specifically, the admission packet provided to all patients contained an incorrect phone number for the home health hotline: Patients # 1-19  Failure to advise patients of the availability of the toll-free HHA hotline creates the potential for unmet patient needs, and possible negative patient outcomes.  On 04/07/09 the incorrect HHA hotline number was discussed with the Administrator and Director of Patient Services. She stated this would be corrected immediately, and all patients will be notified in writing.	G 116	G 116  The Administrator will ensure that all admission packets will contain the correct toll free Home Health Agency hot line number established by NYS for patients' questions and complaints. The toll free HHA hot line number has been corrected and all patients have been notified in writing of this correction. (4-20-09) The Administrator will ensure that the admission packets are reviewed monthly for correct information and that the staff is inserviced with the correct hot line number and our responsibilities to our patients for their questions and complaints by 7-3-09.	
G 118	484.12(a) COMPLIANCE WITH FED, STATE, LOCAL LAWS  The HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations. If State or applicable local law provides for the licensure of HHAs, an agency not subject to licensure is approved by the licensing authority as meeting the standards established for licensure.	G 118	acceptable 6/11/09 Pamela Williams RN	

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G 118	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: HV</p> <p>1. Based pm a review of 1 patient record (patient #5), where the patient was not admitted to the agency until 15 days after the initial referral, and interview of the Administrator, evidence is lacking in 1 record that the agency ensured their services were available to all persons without regard to age, race, color, creed, sex, national origin, disability, service need intensity, location of patient's residence in the service area, or source of payment per NYCRR 10, part 763.5 (e). Specifically, the agency delayed performing an initial nursing assessment by 15 days, based solely on the fact that the patient's medicaid approval had not been obtained. This resulted in the patient, whose primary diagnosis was paranoid schizophrenia, to receive a haldol (antipsychotic medication) injection 15 days late. Specifically:</p> <p>Patient # 5 was admitted to the agency on 01/13/09. The 01/08/09 plan of care included a primary diagnosis of paranoid schizophrenia, and haldol, 200 mg by intramuscular injection every 4 weeks.</p> <p>On 04/06/09 the Administrator provided to the surveyor a computer print out dated 12/29/08, which was 15 days prior to the patient's admission to the agency. The printout documented the following:</p> <ul style="list-style-type: none"> <li>- the agency received a referral from an adult home to provide monthly haldol injections for the patient "per physician order" on 12/29/08.</li> <li>- the agency was not a provider in the patient's managed medical program</li> <li>- the patient would not be admitted into the</li> </ul>	G-118	<p>G 118</p> <p>1. The Administrator will ensure that all referrals are reviewed promptly for clinical, financial and staff appropriateness before accepting the patient for services. All efforts will be made to find the appropriate agency if this agency can not accept the referral. The MD, referral source and patient will be immediately contacted with issues and the progress being made and that all of this assistance will be documented in the referral log. The patient will not be turned away until an appropriate agency is assigned. Referrals will be reviewed daily and appropriate action taken promptly.</p> <p>Completion date to inservice staff is 5-21-08.</p> <p>acceptable</p> <p>Paula Williams</p> <p>6/11/09</p>		

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BINGHAMTON, NY 13905

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G 118	<p>Continued From page 3.</p> <p>agency "due to insurance"</p> <ul style="list-style-type: none"> <li>- the agency notified the referral source</li> </ul> <p>The agency failed to:</p> <ul style="list-style-type: none"> <li>- assess the patient to determine if the agency could meet the patient's needs until 15 days after receiving the referral and/or</li> <li>- coordinate with the referral source a response to the physician that the injection was not given as ordered.</li> </ul> <p>As a consequence the patient was not admitted to the agency until 01/13/09 which was 15 days after the referral, and the patient did not receive the haldol injection until 15 days after it was due, per the 01/13/09 nursing assessment.</p> <p>On 04/07/09 the surveyor made an observational home visit with the Skilled Nurse (SN). During the visit the patient appeared anxious about his upcoming haldol injection, and reminded the SN several times of specifically when the next injection was due. Additionally, the adult home staff stated to the surveyor that the patient feels compelled to frequently remind the staff about his haldol injection 2-3 days prior to it being due.</p> <p>On 04/16/09 the patient record was reviewed with the Regional Vice President, Administrator, and Director of Patient Services. The Administrator confirmed that the agency failed to assess the patient because the agency was not a participating provider in the patient's insurance. She added that the agency was able to assess and admit the patient on 01/13/09 because the patient had been switched to a medicaid program that the agency did accept, however, it was the referral source who provided this assistance to the patient, and not the agency.</p>	G 118		

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G 118	Continued From page 4  Failure of the agency to ensure that services are available to all persons regardless of their source of payment has the potential for unmet needs of medically compromised residents in the community, and possible negative outcomes for this population.  2. Evidence is lacking in 12 of 15 personnel records reviewed that the agency is in compliance with all applicable Federal, State, and local laws and regulations. Specifically, the agency failed to ensure that Title 10 of NYCRR Part 763.13 are implemented. Employees # A - F, J - O  Failure to maintain complete personnel records has the potential for the spread of communicable diseases to all patients in the care of the agency, and for unqualified employees to be providing patient care.  - In five of fifteen personnel records, the initial employee health assessment was signed by an RN, and not a physician, prior to the employee assuming duties of the job. Specifically, according to the New York State Department of Health Memoranda (series 88-1) distributed on 01/04/88, the individuals who may complete the pre-employment physical examination are physicians, nurse practitioners, physicians assistants. The employees affected are B, E, J, K, M.  - In 6 of 15 records reviewed, the personnel record failed to include evidence of immunization against rubella, as required by Title 10 of NYCRR Part 763.13 (1). This includes employees B, E, F, J, M, O	G 118	G 118 1. The Administrator will ensure that all referrals are reviewed promptly for clinical, financial and staff Appropriateness before accepting the patient for services. All efforts will be made to find the appropriate agency if this agency can not accept the referral. The MD, referral source and patient will be immediately contacted with Issues and the progress being made and that all of this assistance will be documented in the referral log. The patient will not be turned away until an appropriate agency is assigned. Referrals will be reviewed daily and appropriate action taken promptly. Completion date to inservice staff is 5-21-09  The Director of Clinical practice will oversee that the following Gentiva policy/process will be carried out monthly by the RTC (records coordinator). As of 6/1/09 a tickler file was established containing all the required yearly documents. These documents will be checked the first of every month by the records coordinator, under the direction of the DCM. This file will include all yearly  6/11/09 acceptable Paula Williams RN	

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G 118	Continued From page 5  - In 3 of 15 records reviewed, the personnel record failed to include evidence of immunization against measles as required by Title 10 of NYCRR Part 763.13 (2), (i). This includes employees F, J, and O.  - In 13 of 15 records reviewed, the personnel record failed to include evidence that the agency verified personal identification of the employee prior to employment as required by Title 10 of NYCRR Part 763.13 (4) (f). Additionally, the records do not meet "Policy 8-1" in the agency's own Policy Manual, which requires that new associates present original documents on the I-9 form on the first day of employment. Employees A - F, H, J - O  - In 5 out of 15 records reviewed, the personnel record failed to include verification of employment history, and recommendations from other persons unrelated to the applicant as required by Title 10 of NYCRR Part 763.13 (4) (g). Employees C, F, L, M, O  The above information for all examples was reviewed with the Administrator, and Director of Patient Services on 4/15/09. No additional information was provided.	G 118	requirements such as medical, health, certifications, supervisions and licenses, as outlined in Gentiva Policy (8-3). <ul style="list-style-type: none"><li>• I-9 documents are reviewed and retained in a separate confidential location. As of 6/4/09 all required I-9's are filed and maintained by the records coordinator. The Administrator and the DCM are knowledgeable in this process.</li><li>• All three of the deficient immunization records have been obtained and filed.</li><li>• Prior to employment, all employment verification will be completed before we extend an offer. This verification will be obtained by the records coordinator, under the direction of the DCM.</li><li>• All missing MMR titers have been obtained. Going forward upon hire, titers will be obtained as a condition of employment.</li><li>• Five of the deficient health assessment forms lacked an MD/NP signature. All were returned with an MD/NP signature and placed in employees file.</li><li>• All personnel files were reviewed by the records coordinator for the above items and found to be in order.</li></ul>		
G 128	484.14(b) GOVERNING BODY  A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.  This STANDARD is not met as evidenced by: Based on a review of 19 clinical records, review of Governing Body meeting minutes dated	G 128			

6/11/09 acceptable  
Pam Williams RA

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G 128	<p>Continued From page 6</p> <p>10/21/08, 04/03/08, and Professional Advisory Committee meeting minutes dated 02/28/08, 06/27/08, 03/26/09, evidence is lacking in 18 clinical records that the Governing Body effectively oversees the operation and management of the agency. Patients # 1 - 17, 19</p> <p>Failure of the Governing Body to provide adequate oversight and direction of the agency resulted in negative outcomes for one patient (patient # 13) and multiple repeat standard level deficiencies.</p> <p>Specifically, evidence is lacking that the following Governing Body responsibilities are being performed:</p> <ul style="list-style-type: none"> <li>- Exercising its ability for the overall management and supervision of the agency. Evidence is lacking that the Governing Body understood its responsibility to provide oversight and direction specific to the agency. Specifically, the Governing Body minutes dated 10/21/08 and 04/03/08 for a meeting at the corporate level lack a specific reference to the CHHA located in Binghamton, New York. The minutes contain a general statement: "No substantive recommendations had been made for Governing Body consideration. Where noted, office administrators and staff will respond to recommendations within their respective markets".</li> <li>- Ensuring that supervision of all patient care is provided and readily available. Specifically, that supervisors are ensuring that: case coordination and case management are being performed; patients receive the necessary services based on a professional assessment of the patient's needs;</li> </ul>	G 128	<p>G128</p> <p>The Governing Body will provide oversight and direction to the Agency with management and supervision of the agency, as evidence of specific reference to this agency in the Governing Body meeting minutes.</p> <ul style="list-style-type: none"> <li>• The Administrator will ensure that the</li> </ul> <p>The regional quarterly PAC and QAC meeting minutes are accurate and complete. With regard to documentation of all clinical outcome deficiencies obtained through internal random, focused and supervision reviews as well as the trends and action plans. These minutes will be mailed to the Governing Body for their consideration. Direction and recommendations from Gentiva's corporate Compliance Officers Will provide oversight and direct management of the Agency. Reviews from compliance will be delivered to this branch via email, direct contact and also through focused internal branch audits which are randomly completed through the year by the compliance department. State audits are reviewed by the VP of Compliance and recommendations will be made via fax or email to the branch.</p> <p>(See actions under G 140, 143, 158, 159, 164, 171, 172, 118, 153, 250) Next QAC meeting scheduled for 6-12-09. Next PAC Meeting scheduled 6-26-09</p> <p>Per agency Administrator Completion date is 6/26/09</p>	

6/11/09 acceptable  
P. Williams R. H. USC

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G 128	Continued From page 7 plans of care are completed and followed; changes in patient condition are identified and reported to the physician; nursing assessments are complete and accurate; and nurses are qualified, trained, and supervised. G140, 143, 158, 159, 164, 171, 172  - Ensuring that the agency is in compliance with all state and local laws. G 118  - Ensuring that the agency's Professional Advisory Committee reviews and revises agency policies and procedures, as needed and at least annually. G 153  - Ensuring internal agency audits are of sufficient scope to identify quality of care issues and deficient practices, and that resolutions are developed and implemented. G250  - Ensuring that the agency is consistently functioning in full compliance with all applicable rules and regulations as outlined in this report.	G 128			
G 140	484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE  Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).  This person, or similarly qualified alternate, participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.	G 140			



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G 140	<p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Based on review of 19 patient records and interviews with the Administrator and DPS, and review of agency policies and procedures, evidence is lacking in 18 records the Director of Patient Services (DPS) ensured the provision of adequate supervision of patient care. Patients # 1 - 17, 19</p> <p>Lack of adequate supervision has the potential for agency wide unmet patient needs, and possible negative patient outcomes.</p> <p>Specifically, evidence is lacking the DPS is:</p> <ul style="list-style-type: none"> <li>- Ensuring that coordination/case management is being performed consistently and that all pertinent patient information is communicated to all individuals providing care, and documented in the clinical record. See G 143</li> <li>- Ensuring that plans of care are consistently being followed. See G 158</li> <li>- Ensuring that each patient's plan of care is complete for all diagnoses, medications and treatments. See G159</li> <li>- Ensuring that the agency's professional staff promptly alerts the physician to any changes in the patient's condition that may suggest a need to alter the plan of care. See G 164</li> <li>- Ensuring that nursing assessments and reassessments are complete and accurately reflect the patient's status and continuing needs. See G171, G172</li> <li>- Ensuring the SNs assigned to provide patient</li> </ul>	G 140	<p>G140</p> <p>The Administrator will ensure that all staff functions under the supervision of the DCM and the MCP. The DCM and the MCP will ensure that those clinicians qualifications are consistent with regulations and compliance by conducting, over-seeing, and evaluating the staff. All staff is required to complete these educational courses by the end of the third quarter.</p> <ul style="list-style-type: none"> <li>• Pain Management -6/5/09</li> <li>• Infusion Therapy - 5-21-09</li> <li>• Care Coordination and Documentation</li> <li>• Interim Orders- Verbal Orders</li> <li>• Ostomy Care 6-5-09</li> <li>• Assessing the Patient</li> <li>• Incident Reporting</li> <li>• OSHA-infection control</li> <li>• Patient Home Safety</li> <li>• Performance Improvement</li> <li>• Initiation of Care</li> <li>• Case Management</li> <li>• Joint visits will be made with all personnel furnishing services (field staff). These supervisory visits will be made by either the clinical supervisor, infusion supervisor, the MCP or the DCM.</li> <li>• By 7-31-09 all field staff will have been supervised during a home visit. Going forward supervision of all staff will be completed quarterly.</li> </ul>	

TC 6/11/09

Per administrator  
completion DATE = 7/31/09

6/11/09 acceptable

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Paula Williams

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G 140	<p>Continued From page 9</p> <p>care are qualified. Specifically, Patient # 7 was admitted to the agency on 04/03/09. The 04/03/09 initial nursing assessment documented: the patient had a new colostomy, the patient's daughter was caring for the ostomy, the next SN visit was scheduled for 04/06/09.</p> <p>Although the SN documented that she reviewed colostomy care with the daughter during the initial assessment, evidence is lacking the SN assessed the ostomy site, or observed the daughter performing the colostomy care independently.</p> <p>On 04/09/09 an observational home visit was made by the surveyor with the SN. During the visit, the SN stated to the patient and the patient's daughter, that she had very little experience with ostomy care because her background was in emergency room nursing. She asked the patient's daughter if she (the daughter) could, sometime soon, teach her (the SN) how to perform the ostomy care.</p> <p>The SN's personnel record included a self assessment check list that stated she needed to review ostomy management and teaching. Evidence is lacking the SN's orientation included supervision of the SN performing ostomy care. Despite the documented lack of ostomy skills, and no supervision of the SN performing ostomy care, the SN was assigned to care for this ostomy patient.</p> <p>The patient record was reviewed with the Area Vice President, Administrator, and Director of Patient Services on 04/13/09. No additional information was provided.</p>	G 140	<p>These visits will evaluate and document skills such as</p> <ul style="list-style-type: none"> <li>• complete and accurate assessment of the patient with regard to disease management</li> <li>• coordination/case management, including assessment of the total physical, mental, psycho-social needs,</li> <li>• interdisciplinary case communication via written and oral means.</li> <li>• following a complete and accurate care plan.</li> <li>• communicating with the MD and nursing supervisor regarding changes in condition of patient</li> </ul> <p>Professional skills will be evaluated and documented before assignment. This will be done via a skills check-list book which will be maintained by the MCP.</p> <p>The MCP will ensure that the clinicians supervision and these educational and skills areas are covered by 7-31-09 and that the staff will be supervised quarterly thereafter. Lack of compliance with these areas will result in retraining period, an action plan and a 30 day re-evaluation that will be placed in personnel files.</p>	
G 143	484.14(g) COORDINATION OF PATIENT	G 143	<ul style="list-style-type: none"> <li>• G-140 Pt#7-follow up co-visit was made by the clinical supervisor and clinician to correctly assess patients status and teaching needs with regard to the ostomy and IV care.</li> </ul>	

06/11/09

acceptable -

Raula J. Williams RN  
HNSC

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G 143	<p>Continued From page 10 SERVICES</p> <p>All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 19 clinical records and interviews with the Administrator and Director of Patient Services (DPS), evidence is lacking in 7 records that the nurses are functioning effectively in the role of case manager/case coordinator. Patients # 3, 4, 5, 6, 8, 10, 14</p> <p>Lack of coordination of services has the potential for unmet patient needs and negative patient outcomes.</p> <p>Examples are as follows:</p> <p>HV 1. Patient #6 was admitted to the agency on 03/04/09. The patient resided in an adult home. Evidence is lacking the Skilled Nurse (SN) coordinated and implemented an effective plan to meet the patient's needs as follows:</p> <p>- Between the dates of 03/09/09 and 03/27/09 the Physical Therapist (PT) documented 7 times, and the Occupational Therapist (OT) documented 6 times, that the patient was experiencing pain. Neither the PT or OT assessed or communicated with each other: the location and or intensity of the pain, if the patient was maximizing the as needed tylenol per the plan of care, if the patient needed to be premedicated prior to PT and OT sessions, or if an updated pain management</p>	G 143	<p>G143</p> <p>The DCM and MCP, under the direction of the Administrator will be responsible for carrying out the following methods to ensure that field staff are supported and coordinated effectively to meet the objectives outlined in the POC.</p> <ul style="list-style-type: none"> <li>• Face to face weekly review with each clinician will be done by the MCP, DCM or Clinical Supervisor. Review will incorporate the chart documentation, POC and focus on patient evaluation, progression and implementation of disease management protocols.</li> <li>• Review and monitoring of interdisciplinary communication with regard to following the POC will be carried out by the MCP via case coordination. This will be carried out by daily review of case load, weekly review of all active patients, phone or face to face discussion between the MCP and clinicians.</li> <li>• An inter-disciplinary team will do focused and random reviews quarterly to ensure that the POC is being followed. Any deviations from following the POC will be identified and a retraining process will be instituted.</li> </ul> <p>Patient #6, #8 and # 3 have been discharged</p> <p>Patient # 4</p> <ul style="list-style-type: none"> <li>• Patient medication profile was not reconciled on 2/19. Clinician was retrained in medication review process and case communication was obtained verifying medication change by 5/12/09.</li> </ul>	

TC to adm - 6/11/09 -  
completion DATE = 06/01/09  
acceptable for release 6/11/09

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G 143	<p>Continued From page 11</p> <p>plan needed to be coordinated with the physician for additional pain medication. Additionally, although patient care conferences were held on 03/30/09 and 04/03/09, evidence is lacking the patient's pain was ever discussed.</p> <p>- On 03/17/09 the OT documented that the patient was waiting for a new, wider wheelchair. On 03/20/09 the OT documented that the patient was agitated, and refused the wheelchair for the third time, and that it was unlikely that the vendor would send another wheelchair. Evidence is lacking the OT coordinated a plan with the vendor which would have supported the patient in accepting the new wheelchair, to include the presence of the OT or PT during the attempted deliveries.</p> <p>- On 03/18/09 the physician ordered an MRI for the patient's neck pain. On 03/26/09 the OT visited the patient and documented the patient had cancelled the MRI due to fatigue, and on 04/02/09 the PT documented that another MRI appointment had been made.</p> <p>On 04/07/09 the surveyor conducted an observational home visit with the PT. During the visit the patient stated that he could not attend the MRI appointment due to a runny nose. Evidence is lacking the PT or OT coordinated a plan with each other, or with the physician to ensure the patient ever received the MRI.</p> <p>- On 04/02/09 the PT documented that the patient's aspirin had been discontinued. The PT failed to clarify how he knew this, or confirm this change in the plan with the physician.</p> <p>- During the 04/07/09 observational home visit,</p>	G 143	<ul style="list-style-type: none"> <li>OT personnel were in-serviced regarding obtaining VS every visit by 5/12/09.</li> <li>Too many staff made visits made on the same day. Case communication issue between schedules and disciplines. Staff in-service in May addressing methods of improving communication between staff as to scheduling. This resulted in office reorganization, placing the schedulers and the MCP together, with the DCM and Branch Director in close proximity to facilitate better oversight and communication. Reorganization completed by June 1<sup>st</sup>, 2009.</li> <li>Follow up calls were completed 5/18/09 between supply vendors to clarify payment issues. Pt had no outstanding balances as a result of this follow up.</li> </ul> <p>6/11/09 acceptable - P. Williams R. HNSC</p>		

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G 143	<p>Continued From page 12</p> <p>the PT stated to the surveyor that on 04/02/09 the patient had reported having dark stools, which is a common sign of gastrointestinal bleeding. Although the PT stated that he had reported this to the physician following the 04/02/09 visit, there is no documentation to support this, and evidence is lacking the PT coordinated a plan with the physician to address the patient's change in condition. Additionally, evidence is lacking the PT reassessed the patient's bowel status during the 04/07/09 home visit, or reported the patient's bowel status to the physician.</p> <p>The patient record was reviewed with the Area Vice President, Administrator and DPS on 04/13/09. No additional information was provided.</p> <p>2. Patient #8 was admitted to the agency on 11/10/08. The 11/10/08 plan of care included review of chemotherapy treatment, including side effects, and the 11/10/08 initial nursing assessment indicated that the chemotherapy was to be administered by a Licensed Home Care Services Agency (LHCSA). Although the SN visited the patient 8 times between the dates of 11/22/08 and 12/29/08, evidence is lacking the SN coordinated the care provided by the LHCSA. Specifically the evidence is lacking the SN was aware of the specifics of the chemotherapy that was being provided by the LHCSA as follows:</p> <ul style="list-style-type: none"> <li>- The plan of care did not include: the type, dose, frequency, duration, or administration route of the chemotherapy, or who was responsible for administering the chemotherapy.</li> <li>- The plan of care did not clarify who was responsible for teaching the patient about the chemotherapy. Specifically, the plan of care</li> </ul>	G 143	<p>Patient # 10</p> <ul style="list-style-type: none"> <li>• Discrepancy in edema measurements. Edema measurement in-service to be provided by 7/31/09.</li> <li>• Case communication lacking. Documentation was submitted on chart by 5/12/09.</li> <li>• Med profile inaccurate. Updated and corrected by 5/12/09.</li> <li>• Lack of nutritional supplementation review and accurate documentation of patient's use of ensure. Case conference held between clinician and Branch Director regarding nutritional supplementation with regard to teaching and documentation. Nurse corrected and case communication to physician on chart by 5/12/09.</li> <li>• Wound care notes missing, poor wound care flow documentation. Late entry Notes updated by 5/12/09 and in-service on wound was done on 6/5/09.</li> </ul> <p>6/11/09 acceptable - Paula Williams RN</p>		

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G 143	<p>Continued From page 13</p> <p>included "review chemotherapy treatment, including side effects", however, the plan failed to specify if the LHCSA or the CHHA SN was responsible for reviewing this information with the patient. Evidence is lacking the CHHA SN: provided any teaching to the patient about the chemotherapy, assessed if the LHCSA was providing this to the patient, assessed the status of the patient's chemotherapy, including if it was ongoing, and/or when it was scheduled to be completed.</p> <p>- On 02/09/09 the nursing discharge summary documented that the patient had recently had a port placed for the chemotherapy, and was being discharged because he was no longer homebound. Evidence is lacking the SN specified when the port was placed, or coordinated an updated plan of care for the port with the LHCSA, to include: when the port was placed, the type of port, the care of the port, who was responsible for the care, or if the LHCSA was going to continue to provide services to the patient for teaching.</p> <p>- The SN failed to ever assess the status of the port site, or confirm that it was being assessed by the LHCSA.</p> <p>- Evidence is lacking the SN coordinated a plan for the patient's oxygen. Specifically, on 11/22/08 a physician's order stated continuous oxygen at 2 liters per minute via nasal cannula. On 11/28/08 the SN documented that she contacted the physician, who gave a verbal order to decrease the oxygen to 2 liters, to be used only at hour of sleep, and only as needed. The SN failed to obtain a written order from the physician for the new oxygen plan, and failed to ever assess</p>	G 143			

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G 143	<p>Continued From page 14 the patient's oxygen use.</p> <p>The patient record was reviewed with the Area Vice President, Administrator and DPS on 04/13/09. No additional information was provided.</p> <p>3. Patient # 4 was admitted to the agency on 12/03/08. The SN failed to coordinate an adequate plan for the patient's (peripherally inserted central catheter) PICC line as follows:</p> <ul style="list-style-type: none"> <li>- On 01/15/09 a physician order was obtained by the SN for normal saline flushes one time per week for the PICC when not in use, as well as hepbloc flush to both lumens, flush daily and after each use. The SN failed to identify these orders were conflicting, and failed to clarify the order with the physician.</li> <li>- On 01/25/09 a case communication documented that the daughter had run out of saline syringes to flush the PICC line. On 01/26/09 a communication note clarified that the patient had run out of flush over the weekend, and that the physician's office was to follow up on supplies. On 01/27/09 a communication note documented: the patient had no PICC supplies that day for a blood draw, the daughter was unwilling at that time to receive supplies COD, the physician was going to try and obtain more cost effective supplies. Evidence is lacking the SN coordinated a plan that included: ensuring that the patient had enough PICC supplies prior to the patient running out, assessing how the patient's PICC line was being flushed from 01/25/09 to 01/27/09, assessing for the possible need of social worker services to assist the family in obtaining the needed supplies.</li> </ul>	G 143			

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G 143	Continued From page 15	G 143	TC 6/11/09 Pm		
G 153	<p>The patient record was reviewed with the Area Vice President, Administrator and DPS on 04/13/09. No additional information was provided.</p> <p>484.16 GROUP OF PROFESSIONAL PERSONNEL</p> <p>The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.</p> <p>This STANDARD is not met as evidenced by: Based on reviews of the Professional Advisory Committee (PAC) meeting minutes, agency policies, and an interviews with the Administrator and Director of Patient Services, evidence is lacking the agency's clinical and administrative policies are being reviewed annually by the PAC.</p> <p>On 04/17/09 the surveyor requested to see evidence of the PAC's yearly evaluation of all policies. The Administrator stated: that all policies are not reviewed by the PAC annually, and that the PAC reviews policies and procedures only as needed.</p> <p>Failure of the PAC to review existing policies and procedures for appropriateness has the potential for unmet patient needs and possible agency wide negative patient outcomes.</p>	G 153	<p>G 153</p> <p>The Governing Body will ensure that ALL Clinical and Administrative Policies are reviewed annually, that all new policies are reviewed by the Policy and Practices committee of the Governing Body and approved by the Governing Body. The Chairman of the Policy and Practices Committee will ensure that documented proof of review is included in the Governing Body meeting minutes. The Administrator will ensure that the PAC will also review these policies and will ensure that there is documented proof of this review included in the PAC meeting minutes and reviewed by the Medical Director and Administrator and forwarded on to the Governing Body. The Administrator will ensure that the new policies are reviewed by the PAC committee and that documented proof of this review and acceptance is included in the PAC meeting minutes of 6-26-09 and all meeting minutes thereafter.</p> <p>6/11/09 acceptable</p> <p>Paula J. W. Hansen</p>		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 158	<p>G 158</p> <p>The Administrator will be responsible for ensuring that education and skills are evaluated for all field staff and that supervision is performed on all staff by 7-31-09 and quarterly thereafter. Lack of compliance with any of these areas will result in disciplinary action (See G 140)</p> <p>6/11/09 acceptable</p> <p>Pm</p>		



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Continued From page 16

Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

This STANDARD is not met as evidenced by: Based on a review of 19 clinical records and interviews with the Director of Patient Services (DPS), evidence is lacking in 9 records that the plan of care is consistently being followed. Patients # 1, 3, 4, 7, 11, 12, 13, 17, 19

Failure to follow the plan has the potential for unmet patient needs and negative patient outcomes.

Examples are as follows:

1. Patient #19 was admitted to the agency on 1/08/09 with a primary diagnosis of multiple sclerosis. The 01/08/09 initial nursing assessment documented that the patient lived alone, required assistance getting out of bed, could not shower without assistance, did not change her clothing more than once a week because she was unable to dress herself, refused to eat because she did not want to spill food on herself and soil her clothing, was wheelchair dependent, had an inadequate support system, had an ex husband who came in the morning to help her get out of bed, and who assisted her with bathing one time per week. Evidence is lacking the agency followed the plan of care, and provided HHA services that met the patient's needs.

Specifically, despite the fact that the 01/08/09 plan of care included HHA visits one time per week, and the patient was unable to bathe herself or change her clothing independently, and was

G 158

Patient # 19 patient was offered additional aide services, pt refused.

Patient #13, all clinical staff were instructed on 5/27/08 regarding proper placement of aide services to meet patients needs. OT and MSW reeducated by 5/31/09 regarding timely visits within 7 days.

Patient #4, see G-143

Patient #7, Ostomy supplies were reassessed and we are providing coverage for the Ostomy products, see case communication 4/21/09. 4/28/09 complete reassessment of PICC line, medication profile and ostomy done.

Patient #17 -MSW Case Conference notes state MD orders for MSW was a late order, so visit was timely.

Patient # 1, 3, 11, and 12 have been discharged.

acceptable 6/1/09

Paula J. Williams for

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G 158	<p>Continued From page 17</p> <p>reluctant to eat because of fear of soiling her clothing, the agency provided only 3 HHA visits between the dates of 01/08/09 and 03/06/09. Evidence is lacking the SN: assessed why the HHA visits were not being provided, notify the physician, and/or develop, and implement a plan to ensure the patient's personal care needs were being met.</p> <p>The patient record was reviewed with the Area Vice President, Administrator, and DPS on 04/16/09. No additional information was provided.</p> <p><b>HV</b></p> <p>2. Patient # 1 was admitted to the agency on 1/22/09. The 03/23/09 plan of care included: continuous oxygen via nasal cannula at 2 liters per minute at rest; and 2.5 liters per minute with mild exertion; the SN is to measure the oxygen saturation for shortness of breath as needed, and report to the physician values of less than 90%. The SN failed to follow the plan of care as follows:</p> <ul style="list-style-type: none"> <li>- On 04/04/09 the surveyor made an observational home visit with the SN. At the onset of the visit, the SN noted that the patient was slightly short of breath, and adjusted the O2 from 1.5 liters per minute to 2 liters per minute. Evidence is lacking the SN provided any patient teaching to ensure the patient used no less than 2 liters of oxygen per minute per the plan of care.</li> <li>- As the visit progressed, the patient became increasingly short of breath, and the SN mentioned this to the patient. The patient told her that he was short of breath because of the humidity, and had used his inhaler with no apparent effect. Evidence is lacking the SN measured the patient's oxygen saturation per</li> </ul>	G 158		

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G 158	Continued From page 18 the plan of care.  The patient record was reviewed with the Area Vice President, Administrator and DPS on 04/13/09. No additional information was provided.  3. Patient # 13 was admitted to the agency on 03/19/09. Evidence is lacking the 03/19/09 plan of care was followed as follows:  - The plan of care included Home Health Aide (HHA) services 2 times per week for 8 weeks. With the exception of a HHA visit made on 04/10/09, evidence is lacking the patient received any aide service, or that the physician had been notified that the plan of care had not been followed.  - The plan of care included a Speech Therapist (ST) visit within 7 days, however, the ST failed to visit the patient until day 14, on 04/02/09, and evidence is lacking the physician was notified.  - The plan of care included an Occupational Therapy (OT) and Social Work (SW) visits within 7 days, however, the OT and SW failed to visit the patient until day 8, on 03/27/09.  The patient record was reviewed with the Area Vice President, Administrator and DPS on 04/15/09. No additional information was provided.	G 158			
G 159	484.18(a) PLAN OF CARE  The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional	G 159	G 159  The Administrator will oversee the DCM and MCP who will be responsible for ensuring that education and skills are evaluated for all field staff, ensuring that the POC is complete and accurate by the following: <ul style="list-style-type: none"><li>Quarterly supervision by a clinical supervisor, under the direction of the DCM. Observation of all clinicians care delivery during a home visit and skills will be assessed and an evaluation form will be completed. Those clinicians observed as having deficiencies will be retrained and mentored by the DCM and MCP until reassessment is satisfactory.</li></ul>	Per TC adm on 6/11/09 7/31/09	

6/11/09 - acceptable  
J. Williams

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G 159	<p>Continued From page 19</p> <p>limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on a review of 19 clinical records and interviews with the Area Vice President, Administrator, and Director of Patient Services (DPS), evidence is lacking in 12 records that the plan of care is of sufficient scope to meet the patient needs. Patients # 1, 3, 4, 6, 7, 11, 12, 13, 14, 15, 17, 19.</p> <p>Lack of a complete and accurate plan of care has the potential for unmet patient needs and negative patient outcomes.</p> <p>HV</p> <p>1. Patient #7 was admitted to the agency on 04/03/09. The 04/03/09 plan of care included:</p> <ul style="list-style-type: none"> <li>- daily dressing changes of an abdominal surgical wound</li> <li>- continuous intravenous (IV) infusion of zosyn (antibiotic) 8 gm in 500 cc of normal saline at 22.5 cc per hour, 24 hours per day, via a double lumen peripherally inserted central catheter (PICC).</li> <li>- 20cc normal saline flush after blood draws.</li> </ul> <p>The 04/03/09 initial nursing assessment documented: the patient had a new colostomy; the patient's daughter was the primary caregiver and providing: the daily dressing changes, colostomy care, and IV medication administration. The plan of care failed to include:</p> <ul style="list-style-type: none"> <li>- a plan to revisit the patient until one week after</li> </ul>	G 159	<ul style="list-style-type: none"> <li>• All POC will be reviewed by the MCP/DCM at specific time points (100% SOC /recertification's/ ROC/Discharges for completeness and accuracy, using a standard Gentiva audit tool, developed by the Gentiva compliance department, which will ensure consistent accuracy.</li> <li>• MCP and DCM will review all other time points by the method of random chart audits, focused audits on identified problem areas or those patients with high acuity/ potential for negative outcomes. Per Gentiva Policy clinical record reviews will be conducted no less then every 60 days.</li> <li>• Review of all elements of the POC with regard to diagnoses, mental status, services and DMB, frequency of visits, medical necessity of interventions and outcomes measurements based on disease management protocols.</li> <li>• DCM will trend outcomes of above audits and present data to the Administrator for purposes of staff development. Areas or clinicians of concern will be retrained or educated both one on one with the DCM or by mandatory in-services. Monthly mandatory in-services are presented at the beginning of the month and consist of issues identified through compliance, internal audits and state surveys. Audit outcomes will be reported to the PAC committee as well as the mailed to Corporate compliance.</li> </ul>	

6/11/09 acceptable Paul J. Williams

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G 159

Continued From page 20

the initial nursing assessment. Specifically, although the daughter was providing colostomy care, wound care, and administering IV medications to the patient for the first time, evidence is lacking the SN ever observed the daughter providing this care. The SN failed to develop a plan that included a reassessment of the patient the following day to observe, and provide teaching, guidance, and support to the primary caregiver.

On 04/09/09 the surveyor conducted an observational home visit with the SN. Following the conclusion of the SN visit the surveyor interviewed the patient's daughter. The daughter confirmed that she had no prior experience performing the above procedures for her mother at home:

- specification of which lumen the medication should infuse through, and which lumen should be used for blood draws
- a plan of care for the colostomy. Specifically, the plan failed to include: the type of ostomy appliance, the frequency of appliance change, the care of skin surrounding the ostomy, who was responsible for providing the ostomy care, and a plan for the SN to assess the ostomy site.
- a complete wound care plan. Specifically, the initial nursing assessment included a wound flow sheet which depicted 2 wounds, however, the plan of care included wound care for only 1 wound.

The patient record was reviewed with the Area Vice President, Administrator, and Director of Patient Services on 04/13/09. No additional

G 159

Patient # 7 (G-158)

Patient #4 (G-143 &amp; 158)

Patient #17 notes of 4/28/05 nursing notes include complete reassessment of patients IV site, ostomy specifics and clarification of wound care reviewed with the nurse and

family during a co-visit with the IV Clinical supervisor in attendance.

Patient # 13 Upon recert on 5/18/09-the following issues were addressed and corrected, nutritional needs, specific amounts and times of ensure. G-tube type placement and flushing orders as well as all medications given via G-tube. Leg brace doffing and donning schedule. Bladder training schedule clarified. Pain management included clarification with clinician and pain control documented by time of recert.

Patient #14-lack of coordination between 3 disciplines-in-service is care coordination completed by 6/1/09. edema measurement at Soc discussed with clinician who felt this was done in error, chart review with DCM reveals no clinical need -discussed with clinician. Aide should have been utilized more frequently. In-service on when and how to use aides and team coordination to be scheduled by 7/31/09. No aide POC, one specific clinical supervisor is now assigned to monitor all aspects of aide services beginning 6/1/09 and will be held accountable for oversight of this process by the Administrator..

Comp  
date  
7/31/09  
BRT Administrator  
6/11/09  
Paula Williams  
P.W.  
Acceptable  
6/11/09  
Paula Williams  
P.W.

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G 159	<p>Continued From page 21 information was provided.</p> <p>2. Patient #4 was admitted to the agency on 12/03/08. The 02/01/09 plan of care failed to include:</p> <ul style="list-style-type: none"> <li>- a plan for care for the PICC line. Specifically, the 01/28/09 recertification nursing assessment documented that the patient had a PICC line which the daughter flushed proficiently. The 01/26/09 a physician order specified flush PICC weekly with 10cc normal saline when not in use, but also specified heparin flush to both lumens, flush daily and after each use. The SN failed to clarify the conflicting order with the physician.</li> </ul> <p>Additionally, the plan of care failed to include a PICC line dressing type and frequency, and who is responsible for the dressing change.</p> <p>Additionally, the plan of care failed to include a plan for the SN to assess for PICC line migration, including reporting parameters of external catheter length to the physician.</p> <ul style="list-style-type: none"> <li>- a plan for care of the abdominal wound. Specifically, the 01/28/09 recertification assessment documented that the daughter changes the dressing, however, neither the assessment or plan of care specified the type or frequency of the dressing change.</li> <li>- a complete and accurate plan for care of the chest wound. Specifically, the 01/28/09 recertification assessment documented that the dressing was being changed at the hospital 3 times per week, and by the agency, and the plan of care specified that the daughter was to be instructed in the dressing change by the agency</li> </ul>	G 159	<p>Patient #19 Pt POC did not meet patients needs regarding safety in the home.</p> <p>Discussion with MCP and case manager regarding use of PER's unit for patient. Patient not agreeable but is allowing clinician to work with VESID to have home modifications to improve safety in the home.</p> <p>Patient # 1, 3, 11, 12 and 15 have been discharged.</p> <p>6/11/09 ace- JW</p>	

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NAME OF PROVIDER OR SUPPLIER

GENTIVA HEALTH SERVICES BINGHAMTON

STREET ADDRESS, CITY, STATE, ZIP CODE

1249 FRONT STREET, SUITE 110  
BINGHAMTON, NY 13905

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G 159	<p>Continued From page 22</p> <p>SN. The plan of care failed to clarify who was responsible for changing the dressing, and the frequency of the dressing change.</p> <p>- On 04/09/09 the surveyor made an observational home visit with the SN and the following discrepancies were identified in the 02/01/09 plan of care:</p> <p>The plan of care included xanax daily, however, the patient stated this was discontinued in February 2009, and the patient's medication list did not reflect this.</p> <p>The patient stated she has been using an albuterol inhaler for years, however, the plan of care did not include this.</p> <p>The patient stated she was drinking ensure as a dietary supplement, however, the plan of care did not include this.</p> <p>The patient record was reviewed with the Area Vice President, Administrator, and Director of Patient Services on 04/13/09. No additional information was provided.</p> <p>3. Patient # 17 was admitted to the agency on 01/30/09 with a primary diagnosis of muscle weakness and secondary diagnosis of total hip replacement. The 01/30/09 initial nursing assessment documented that the patient: had dementia; was non-ambulatory; was bedfast and wheelchair fast; required assistance with bathing, dressing, toileting; had 6 hours of aide service through a LHCSA, and the daughter assisted with personal care. The 01/30/09 plan of care included PT services 2 times per week for 8 weeks, and HHA service 2 times per week for 4 weeks, and the 03/31/09 plan of care included PT services to continue 2 times per week for 4 weeks. Although</p>	G 159		

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G 159	Continued From page 23 the patient required considerable assistance with personal care, and continued to be wheelchair and bedfast, and required ongoing PT services, and a privately hired HHA, the SN failed to document why the plan of care did not include HHA services after the first 4 weeks.	G 159			
G 164	The patient record was reviewed with the Area Vice President, Administrator on 04/16/09. No additional information was provided. 484.18(b) PERIODIC REVIEW OF PLAN OF CARE  Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.  This STANDARD is not met as evidenced by: Based on a review of 19 clinical records, and interviews with the Area Vice President, Administrator, and Director of Patient Services (DPS), evidence is lacking in 2. records that the physician is consulted when changes in the patient condition occur. Patients # 4, 13, Failure to consult with the physician when changes in the patient's condition resulted in a negative outcome for patient #13, and has the potential for unmet patient needs and possible negative patient outcomes agency wide.  Examples are as follows:  1. Patient # 13 was admitted to the agency on 03/19/09. The plan of care included advil 600 mg 3 times per day as needed for pain, and darvocet 50/325 mg 1-2 tabs every 6 hours as needed for pain. On 03/25/09 the physician ordered a SN assessment to be conducted following the	G 164	G 164 <i>TC adm 4/16/09 pmo completion date 7/31</i>  The Administrator will be responsible ensuring that the DCM and MCP will use the above mentioned methods (G159) for purposes of identifying compliance of professional staff with regard to reporting any changes in patient care and follow through when there is a need for altering the POC. The MCP will be responsible for oversight of the clinicians by daily communication with the clinicians, via report, chart review, phone updates on patient's condition changes as they occur and weekly chart review of selected patients so that by months end all current caseloads are reviewed. Patients identified as clinically stable, through daily and weekly communication (both phone and face to face) will have a chart audit to review for appropriateness of POC and possible modification and or discharge.  Patient # 4 Delay in reporting edema (SCIC). In-service to be held by quarter three regarding reporting significant changes in patient's condition.		

Patient #13-Significant level of pain not controlled and not reported to MD. Clinical in-service as above with regard to SCIC and pain assessments.



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G 164	<p>Continued From page 24</p> <p>insertion of a gastric tube for teaching the family about flushing and feeding via the tube. The orders included for days 1 and 2 post tube insertion: flush with 80cc tap water 2 times per day, and on day 3, to start 1/2 can jevity with 30 cc tap water flush pre and post feeding. The Skilled Nurse (SN) failed to report to the physician: the patient's decreased fluid and nutritional intake, and increased pain, and the SN failed to advocate for an adequate pain management plan for the patient, which resulted in the patient suffering uncontrolled pain for at least 2 days as follows:</p> <p>- On 04/09/09 the SN visited the patient at 09:33 AM and documented: the patient had a gastric tube placed, was experiencing constant abdominal pain at an intensity level of 8 out of 10, had not eaten anything for 2 days. The SN documented that she flushed the Gastric tube without difficulty, administered darvocet N-100 mg to the patient via the patient's gastric tube, and instructed the family in flushing the gastric tube.</p> <p>Although the SN documented calling the physician that day to report the patient had fallen, the SN failed to report: the patient's increased pain, the patient had not eaten in 2 days, what the patient's fluid and food intake had been, and failed to clarify if the patient was to be taking nothing by mouth. The SN failed to reassess the patient until the following day on 04/10/09.</p> <p>- On 04/10/09 the SN visited the patient and assessed the patient was experiencing constant abdominal pain which had increased to an intensity of 10 out of 10. The SN failed to report to the physician: the patient's continued uncontrolled pain, or if the patient was maximizing the</p>	G 164			

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G 164	<p>Continued From page 25</p> <p>available pain medication per the plan of care which included darvocet 50/325 mg, 1-2- tabs every 6 hours as needed. Instead the SN documented that the patient was going to try advil, and that she advised the patient to try to move around after taking 2 darvocet. The SN failed to report the change in patient condition to the physician, and advocate for an updated plan of care, including a more effective pain management plan, and an immediate reassessment of the patient's pain. This resulted in the patient's pain status being unknown until the SN's next visit, 3 days later on 04/13/09.</p> <p>The patient record was reviewed with the Regional Vice President, Administrator, and Director of Patient Services on 04/15/09. No additional information was provided.</p> <p>2. Patient #4 was admitted to the agency on 12/03/08. On 02/01/09 the SN visited the patient and assessed that the patient had no edema noted. On 02/10/09 and 02/20/09 the SN assessed that the patient had 1 plus pitting edema of her bilateral lower extremities, and on 02/27/09 the SN assessed that the patient had 2 plus pitting edema of her bilateral lower extremities. Evidence is lacking the SN reported the progressing edema to the physician until 03/06/09.</p> <p>The patient record was reviewed with the Area Vice President, Administrator, and Director of Patient Services on 04/13/09. No additional information was provided.</p>	G 164			
G 171	<p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse makes the initial evaluation</p>	G 171			

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G 171	<p>Continued From page 26 visit.</p> <p>This STANDARD is not met as evidenced by: Based on a review of initial nursing assessments in 19 clinical records, and interviews with Director of Patient Services (DPS), evidence is lacking in 6 records the initial nursing assessments are of sufficient scope to ensure that all patient needs are met. Patients # 3, 7, 11, 12, 13, 15</p> <p>Lack of complete and accurate nursing assessments has the potential for unmet patient needs and possible negative patient outcomes.</p> <p>Examples are as follows:</p> <p>1. Patient # 13 was admitted to the agency on 03/19/09. The 03/19/09 initial nursing assessment was inaccurate or incomplete as follows:</p> <ul style="list-style-type: none"> <li>- The SN documented the patient had bruising on her arms, however, the SN failed to assess the size of the bruising, or investigate how the patient sustained the bruises.</li> <li>- The SN documented: the patient had uncontrolled diabetes for 1 month, there was no treatment at the time of the assessment, the patient was not checking blood sugars. The SN failed to document where she obtained this information from, or if she consulted with the physician regarding this.</li> </ul> <p>The patient record was reviewed with the Area Vice President, Administrator, and Director of Patient Services on 04/15/09. No additional information was provided.</p>	G 171	<p><i>Completion</i> G171 <i>Per TCE adm.</i> Date <i>6/12/09</i></p> <p>The Administrator, DCM and MCP will be responsible for ensuring that education and skills of professional clinicians rendering the initial evaluation and all assessments are well skilled in all aspects of case management, disease management and patient evaluation through the re-education of the case management process. 100% of the SOC will be reviewed by the MCP or DCM with regard to accurate nursing assessments. Clinical staff involved were consulted both individually by the MCP and as a group by the Administrator on or by 6/1/09. Specific clinical educational needs will be grouped both by using the skills check list and by trending the results of all audits by 6/12/09. The outcome will be implemented by the DCM as a skills fair by the end of the 3<sup>rd</sup> quarter.</p> <p>Patient# 7-addressed in G-159</p> <p>Patient # 15, 11, 3, 12, have been discharged</p> <p><i>6/11/09</i> <i>acceptable</i> <i>Paul J. Williams</i></p>	

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G 171	<p>Continued From page 27</p> <p>2. Patient # 15 was admitted to the agency on 03/14/09. The plan of care included a secondary diagnosis of diabetes, and glyburide (oral hypoglycemic medication). The 03/14/09 initial nursing assessment was inaccurate or incomplete as follows:</p> <p>Although the 03/14/09 plan of care included assess and instruct the patient for signs and symptoms of hypo and hyper glycemia, evidence is lacking the SN assessed the patient's diabetic status. Specifically, the SN failed to: assess the frequency with which the patient was testing his blood sugar; discuss with the patient the blood glucose values that were reportable to the physician; observe if the patient was able to use a glucometer properly, or if the patient had a glucometer in his home.</p> <p>On 03/26/09 the SN visited the patient and documented that the patient performed his own glucose monitoring without problems, and that the patient's blood glucose was 165 during that visit, however, the SN never clarified with the physician the frequency or parameters for the blood sugar testing.</p> <p>The patient record was reviewed with the Area Vice President, Administrator, and Director of Patient Services on 04/16/09. No additional information was provided.</p> <p>3. Patient # 11 was admitted to the agency on 03/08/09. The 03/08/09 plan of care included a secondary diagnosis of diabetes, and glipizide 5 mg daily (oral hypoglycemic). The 03/08/09 initial nursing assessment documented the patient was legally blind.</p>	G 171		

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G 171	Continued From page 28  The SN assessed that the patient was independent in taking her medications, and that she recommended that the patient use a med sorter. The SN failed to assess how the patient would be able to do this if she is legally blind, and how she was currently able to take her medications despite being legally blind.  The patient record was reviewed with the Area Vice President, Administrator, and Director of Patient Services. No additional information was provided.	G 171		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse regularly re-evaluates the patients nursing needs.  This STANDARD is not met as evidenced by: Based on a review of 19 clinical records and interviews with the Administrator and Director of Patient Services (DPS), evidence is lacking in 7 records that Skilled Nursing (SN) reassessments are of sufficient scope to identify changes in the patient's condition which may require re-evaluation and/or modification in the plan of care. Patients # 2, 4, 6, 7, 9, 10, 12.  Lack of complete and accurate nursing assessments have the potential for unmet patient needs and negative patient outcomes.  Examples are as follows:  HV 1. Patient #2 was admitted to the agency on 03/18/09. During the 60 day certification period,	G 172	<p>Per TC Admin on 6/11/09 G 172 completion DATE → 7/31/09</p> <p>The Administrator will be responsible for ensuring that the DCM or clinical supervisor will conduct weekly chart reviews on the visit notes of all clinicians identified as out of compliance and all new clinicians to determine that the re-evaluation of the patient is clinically appropriate.</p> <ul style="list-style-type: none"> <li>• Reviews may be random, focused or part of the weekly case conference. Focused will include a 100% audit on any chart review noted to be out of compliance.</li> <li>• Recommendations for re-education of the staff will be based on the outcome of these audits.</li> <li>• Chart audits will review assessment and reassessment notes at the QAC meeting, trends and recommendations for retraining will also be discussed at the interdisciplinary Quality Assurance Meeting and also at the PAC meeting quarterly.</li> <li>• Methods for educational training will incorporate Gentiva University program (assessment of the Geriatric patient) and other available teaching job aides provided by Gentiva Corporate Compliance. As well as outside in-service (IV certification and review of IV pump management presented by community IV vendor and an</li> </ul>	7/31/09

6/11/09 acceptable [signature] HASC

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G 172	<p>Continued From page 29</p> <p>the patient was admitted to a skilled nursing facility (SNF) for short stay rehabilitation. On 04/06/09 the patient was discharged from the SNF, and on 04/07/09 the surveyor made an observational home visit with the SN to observe the resumption of care nursing assessment.</p> <p>During the assessment, the patient stated she continued to feel weak, especially in the morning, and that she was concerned that she might not make it to the bathroom without falling. The SN voiced her concern to the patient about her safety status, however, the patient refused to consider returning to the SNF or hospital emergency department. The SN notified the physician and nursing supervisor of the patient's status, including the patient's questionable safety status, and arranged for a physician visit the next day. In addition, a home health aide and Physical Therapist (PT) were scheduled to visit the patient the following morning. The SN failed to:</p> <ul style="list-style-type: none"> <li>- assess the patient for the possible need of a personal emergency response system (PERS), or immediate commode.</li> <li>- reassess the patient until 2 days later on 04/09/09 to assess the patient's safety status, or if the patient was seen by the physician, aide, and PT as planned.</li> <li>- contact the physician to ascertain if an updated plan of care, including a plan for the patient's safety, was needed following the patient's physician visit.</li> </ul> <p>This record was reviewed with the Administrator, DPS, Area Vice President on 4/13/09, no additional information was provided.</p>	G 172	<p>Ostomy in-service presented by a community WOCN, both completed by 6/4/09).</p> <p>Patient # 2 pt was discharged before re-evaluation and placed in SNF.</p> <p>Patient #4 pt discharged before re-eval placed in hospice. Review of ongoing documentation reveals the following clinical educational needs</p> <ul style="list-style-type: none"> <li>• Medication Profile review</li> <li>• Edema measurements</li> <li>• Wound documentation</li> </ul> <p>Patient # 7-Re-evaluation on 6/2/09 shows accurate documentation of IV's, wounds, ostomy supplies, and documentation of adequate teaching. Clinician involved had a supervision co-visit done with this patient to teach proper assessment and documentation skills.</p> <p>Patient # 9, 12, and 6 have been discharged.</p> <p>6/11/09 acceptable Pru</p>		

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G 172	<p>Continued From page 30</p> <p>2. Patient #9 was admitted to the agency on 12/02/08. The patient resided in an adult home. The wound reassessments by the SN were incomplete or inaccurate as follows:</p> <ul style="list-style-type: none"> <li>- On 12/11/08, the case manager SN visited the patient and documented minimal drainage from the left arm wound, however, on 12/12/08 a different SN visited the patient and documented the left arm was draining copious amounts of yellow/green drainage, and had a foul odor, and the patient had been sent to the emergency room. There is no explanation as to why there was such a discrepancy between the 2 SN's assessments.</li> <li>Additionally, on 12/12/08 the second SN also documented the right ankle was red and inflamed. The SN failed to document that the patient had burns on his bilateral feet and ankles, which she documented in the Case Communication Notes on the same day.</li> <li>- On 12/15/08 the case manager SN documented in the "Summary Report" that the patient had a new wound on left ankle and foot from wearing boots without socks. Evidence is lacking either of the SNs had identified this new wound during their assessments on 12/11/08 and 12/12/08.</li> <li>- Although the SN documented in the 12/17/08 "Summary/Case Conference Report" that the patient had 2 new wounds on the tops of both legs with green foul drainage, neither of the SNs had identified these new wounds during their assessments on 12/11/08 and 12/12/08 immediately preceding the case conference, and there were no other visits made prior to the 12/17/08 case conference.</li> </ul>	G 172			

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G 172	<p>Continued From page 31</p> <p>The patient record was reviewed with the Area Vice President, Administrator, and Director of Patient Services on 04/17/09. No additional information was provided.</p> <p>3. Patient # 12 was admitted to the agency on 03/08/09. Evidence is lacking the SN reassessments were complete and accurate as follows:</p> <ul style="list-style-type: none"> <li>- On 03/09/09 the SN documented in a communication note that the patient had called to report that she was vomiting, and was planning to call her physician. Evidence is lacking the SN visited the patient to assess the patient's status, or followed up with the patient or physician until 10 days later on 03/19/09.</li> <li>- On 03/19/09 the SN visited the patient, however, failed to assess the patient's gastrointestinal status.</li> </ul> <p>The patient record was reviewed with the Area Vice President, Administrator, and Director of Patient Services on 04/15/09. No additional information was provided.</p> <p>4. HV</p> <p>2. Patient # 4 was admitted to the agency on 12/03/08. Although the agency had an on call schedule, evidence is lacking the patient's needs were being met during off hours of the agency as follows:</p> <p>On 04/09/09 the surveyor made an observational home visit with the SN. Following the conclusion of the SN's visit, the patient stated to the surveyor that sometime during December 2008 she had</p>	G 172			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  337224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/17/2009
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NAME OF PROVIDER OR SUPPLIER  GENTIVA HEALTH SERVICES BINGHAMTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1249 FRONT STREET, SUITE 110 BINGHAMTON, NY 13905
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G 172	Continued From page 32 returned home from the hospital, and was having difficulty with her wound vac. Although she phoned the agency during "off" hours, the SN failed to visit to assess the functioning of the wound vac. The SN instructed her to apply a dressing which she had never done before. The patient went on to say that the supplies for the dressing were left across the room by the SN, which was inaccessible to the patient due to her debilitated condition. The patient stated that although she had called the agency for assistance with the wound vac, the SN did not visit, and eventually her daughter had to repair the dressing.  The agency's on call log for the month of December 2008 included phone calls from the patient on Saturday 12/27/08 at 09:45 AM and 3:47 PM to report that she was having problems with the wound vac. Although the log documented that the patient called back at 4:15 PM that day to report the wound vac was functioning properly, evidence is lacking the on call SN ever responded to the patient's phone calls, or visited the patient until the following day on 12/28/08. The SN failed to assess or clarify the status of the wound vac on 12/27/08 from 0945 AM to 4:16 PM.	G 172		
G 250	484.52(b) CLINICAL RECORD REVIEW  At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.  This STANDARD is not met as evidenced by: Based on a review of the agency's Quality	G 250	G250  <ul style="list-style-type: none"> <li>The DCM will oversee that a multi-disciplinary team conducts a Clinical Record review to ensure that at least 20% of chart records are reviewed Quarterly.</li> <li>The process is a random selection of active and discharged patient records.</li> <li>An action plan will be established base on the outcome of these CRC audit to establish trends and outcomes.</li> <li>The action plan will be formulated based on the results of a standard QA checklist established by Gentiva compliance Department. The written plan will identify the problem and outlined the methods used to bring the issue into compliance as well as</li> </ul>	33 of 35

6/11/09  
acceptable  
PW

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G 250	<p>Continued From page 33</p> <p>Improvement Program, Professional Advisory Committee (PAC) meeting minutes, Governing Body meeting minutes and interviews with the Area Vice President, Agency Administrator and Director of Patient Services, evidence is lacking the agency's Quality Improvement program identified and corrected systemic agency problems. For example:</p> <ul style="list-style-type: none"> <li>- The quarterly audit results report dated May 2008 indicated the following trends: 100% compliance for frequency and duration of services provided per the plan of care, 100% compliance with developing plans of treatment that reflect assessment findings. The Quality Assurance program failed to identify problems in these areas as identified by this survey.</li> <li>- The quarterly audit results report dated May 2008 indicated 73 % compliance with following the plan of care (other than for frequency and duration of services), however, the 06/27/08 PAC committee meeting minutes failed to identify the need for an action plan to correct the problem of failing to follow the plan of care, as identified by the agency's trended auditing results and this survey.</li> <li>- The 3rd quarter trending results documented 31% compliance with following the plan of care. The agency implemented an action plan which included home visits by the Nursing Supervisors with the Skilled Nurses, and review of the documentation, to monitor compliance with following the plan of care, and to continue with quarterly audits to review if visit notes document following the plan of care, and providing staff education as appropriate. The 10/31/08 governing body meeting minutes documented</li> </ul>	G 250	<p>a follow-up review in one month to monitoring its success.</p> <ul style="list-style-type: none"> <li>Any deviation from the standards as evidenced by reviewing the checklist will be compiled by the DCM, and a summary will be presented monthly during the clinical management team meeting. This team will consist of the Branch Director, The Director of Clinical Management, the MCP and Clinical Supervisor as well as a clinical representative.</li> <li>After 3 quarters of improved random clinical audits it will go back to 10% of clinical records review.</li> <li>The PAC committee will review this data quarterly.</li> </ul> <p><i>6/11/09 accept</i> <i>Parejas</i></p>	al

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G 250

Continued From page 34

they reviewed the types of actions necessary to maximize positive outcomes on surveys, however, were not specific as to what the elements of the action plan were.

The 4th quarter action plan documented improved trended results of 94% compliance with following the plan of care. The agency failed to identify that problems with following the plan of care were not resolved as identified in this report.

- The 02/28/08 and 06/27/08 PAC committee meeting minutes have identical documentation indicating that the QA/PAC committee felt the patient records reflected appropriate services were being provided by the agency to meet patient needs, and that utilization of services was appropriate. Evidence is lacking the committee identified any significant clinical areas in need of improvement, as identified in this report.

- Evidence is lacking that the audit tool evaluates quality issues with respect to comprehensive assessment and case management, as identified by this survey. The tool evaluates only the presence or absence of specific information, such as forms. See G 143, G 171, G 172

G 250

G  
250

- The on-call procedure has been reorganized and put in place effective 5/4/09. The procedure is as follows;  
On call supervisor is first line of contact. Supervisory rotation consists of BD, DCM, RN, IV supervisor and Clinical supervisor. The supervisor will take call from the service and triage. The supervisor will make the decision if a visit is needed and on-call clinician will be called. All calls are reviewed daily at morning supervisory meetings and tracked in the on-call log book, including appropriate follow up. All entries are reviewed and signed weekly by the Branch Administrator.

6/14/07 accept [Signature]